

HEALTH REVENUE SHARING AND HEALTH SERVICES ACT OF 1975

REPORT

BY THE

COMMITTEE ON INTERSTATE AND
FOREIGN COMMERCE
TOGETHER WITH SEPARATE, ADDITIONAL
AND MINORITY VIEWS

[To accompany H.R. 4925]



May 7, 1975.—Committed to the Committee of the Whole House
on the State of the Union and ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE

51-0390

WASHINGTON : 1975

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HEALTH REVENUE SHARING AND HEALTH SERVICES ACT OF 1975

May 7, 1975.—Committed to the Committee of the Whole House on the State of
the Union and ordered to be printed

Mr. STAGGERS, from the Committee on Interstate and Foreign Commerce, submitted the following

REPORT

together with

SEPARATE, ADDITIONAL, AND MINORITY VIEWS

[To accompany H.R. 4925]

The Committee on Interstate and Foreign Commerce, to whom was referred the bill (H.R. 4925) to amend the Public Health Service Act and related laws to revise and extend programs of health revenue sharing and health services, and for other purposes, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Page 2, strike out line 12 and all that follows down through and including line 13 on page 10 and insert in lieu thereof the following:

“COMPREHENSIVE PUBLIC HEALTH SERVICES

“(d)(1) From allotments made pursuant to paragraph (4), the Secretary shall make grants to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services.

“(2) No grant may be made under paragraph (1) to the State health or mental authority of any State unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary may require, and shall contain or be supported by assurances satisfactory to the Secretary that—

“(A) the comprehensive public health services provided within the State will be provided in accordance with the State plan pre-

pared in accordance with section 1524(c)(2) or the State plan approved under section 314(a), whichever is applicable;

“(B) funds received under grants under paragraph (1) will (i) be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided, and (ii) not be used to supplant such non-Federal funds;

“(C) the State health authority, and, with respect to mental health activities, the State mental health authority will—

“(i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds received under grants under paragraph (1);

“(ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national reporting system and by such categories as the Secretary may prescribe) a description of the comprehensive public health services provided in the State in the fiscal year for which the grant applied for is made and the amount of funds obligated in such fiscal year for the provision of each such category of services; and

“(iii) make such reports (in such form and containing such information as the Secretary may prescribe) as the Secretary may reasonably require, and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports;

“(D) the State mental health authority will—

“(i) establish and carry out a plan which—

“(I) is designed to eliminate inappropriate placement of persons with mental health problems in institutions, to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate; and

“(II) shall include fair and equitable arrangements, as determined by the Secretary, to protect the interests of employees affected by actions taken pursuant to such plan, including arrangements designed (to the extent feasible as determined by the Secretary) to preserve employee rights and benefits and to provide appropriate training and retraining of such employees who are employed by the State or any of its political subdivisions;

“(ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) with the State; and

“(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of followup care by community mental

health centers (or, if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities.

“(3) The Secretary shall review annually the activities undertaken by each State with an approved application to determine if the State complied with the assurances provided with the application. The Secretary may not approve an application submitted under paragraph (2) if the Secretary determines—

“(A) that the State for which the application was submitted did not comply with assurances provided with a prior application under paragraph (2), and

(B) that he cannot be assured that the State will comply with the assurances provided with the application under consideration.

“(4) In each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated for such year under paragraph (7) among the States on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the population of the States available from the Department of Commerce.

“(5) The Secretary shall determine the amount of any grant under paragraph (1); but the amount of grants made in any fiscal year to the public and mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

“(6) In any fiscal year—

“(A) not less than 15 per centum of a State's allotment under paragraph (4) shall be made available only for grants under paragraph (1) to the State's mental health authority for the provision of mental health services; and

“(B) not less than—

“(i) 70 per centum of the amount of a State's allotment which is made available for grants to the mental health authority, and

“(ii) 70 per centum of the remainder of the State's allotment,

shall be available only for the provision services in communities of the State.

“(7) (A) For payments under grants under paragraph (1) there are authorized to be appropriated \$100,000,000 for fiscal year 1976, and \$110,000,000 for fiscal year 1977.

“(B) For payments under grants under paragraph (1) for establishing and maintaining programs, described in applications under paragraph (2), for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension there are authorized to be appropriated \$15,000,000 for fiscal year 1976, and \$15,000,000 for fiscal year 1977.”

Page 11, line 13, strike out “\$50,000,000” and insert in lieu thereof “\$55,000,000” and on line 14 strike out “\$55,000,000” and insert in lieu thereof “\$60,000,000”.

Page 13, line 25, strike out "such" and insert in lieu thereof "the Public Health Service".

Page 32, strike out lines 8 and 9 and insert in lieu thereof "except, in the case of an entity which has not received a grant under this section, the requirement for the pro-".

Page 33, line 6, strike out "center" and insert in lieu thereof "center's".

Page 35, line 15, insert a single quotation mark immediately following "deficit".

Page 51, line 18, strike out "accordance" and insert in lieu thereof "accordance".

Page 56, strike out lines 23 and 24 and insert in lieu thereof "center or other entity which received a grant under section 220, 242, 243, 251, 256, 264, or 271 of this title (as in)".

Page 64, line 21, insert quotation marks immediately before "PART".

Page 67, line 8, strike out "and" and insert before the period in line 9 the following: "; and (iii) for the promotion of community awareness of the specific locations in which, and the specific social and other conditions under which, sexual attacks are most likely to occur".

Page 70, line 19, insert a comma immediately after "plan".

Page 77, immediately following line 19, insert "REPORT".

Page 78, insert after line 16 the following:

CONFORMING AMENDMENTS

Sec. 305. (a) Section 401 of the Mental Retardation Facility and Community Mental Health Centers Construction Act of 1963 is amended—

(1) by striking out paragraph (c);

(2) by amending paragraph (d) to read as follows:

"(d) The terms 'nonprofit facility for persons with developmental disabilities' and 'nonprofit private institution of higher learning' mean, respectively, a facility for persons with developmental disabilities and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term 'nonprofit private agency or organization' means an agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations."; and

(3) by—

(A) striking out "or part A of title II" in paragraph (h)(1),

(B) by striking out in paragraph (h)(2) "(A)" and "; and (B) for any project under part A of title II may not exceed 66⅔ per centum of the costs of construction of such project or the State's Federal percentage, whichever is the lower", and

(C) by striking out "or under part A of title II" in paragraph (h)(3).

(b) Section 403 of such Act is amended—

(1) by striking out "or section 204 in the case of a community mental health center," in subsection (a),

(2) by striking out "or section 206, as the case may be," in such subsection,

(3) by striking out "or 205" in subsection (b), and

(4) by striking out the second sentence of subsection (c) (1).

(c) Section 404 is amended by striking out "or 205", "or 204(b)", and "or 206".

(d) Section 405 is amended—

(1) by striking out "or 205" in paragraph (1) (A),

(2) by striking out "or section 204 (in case of a community mental health center)" in such paragraph,

(3) by striking out "or community mental health center, as the case may be," in paragraph (2),

(4) by striking out "or such center as a community mental health center" in such paragraph,

(5) by striking out "or center" each place it occurs in the matter following paragraph (2), and

(6) by striking out "or community mental health center" in such matter.

(e) Section 406 is amended by striking out "or community mental health center".

Page 84, beginning in line 12, strike out "in which not more than six thousand migratory agricultural workers and their families reside for more than two months—" and insert in lieu thereof "which are not high impact areas—".

Page 86, beginning in line 9, strike out "in which not more than six thousand migratory agricultural workers and their families reside for more than two months—" and insert in lieu thereof "which are not high impact areas—".

Page 90, line 2, strike out the semicolon and insert in lieu thereof a comma.

Page 25, line 17 strike out "subsection (f)" and insert in lieu thereof "the subsection (f) added by Public Law 93-248".

Page 122, line 14, insert "next to" immediately after "The".

Page 122, line 17, strike out "1975" and insert in lieu thereof "1973".

SUMMARY

H.R. 4925, as reported by the Committee, proposes to continue, without change, authorities for block grants to States for health services, and project grants for family planning, community mental health centers, migrant health programs and community health centers for fiscal year 1975 at levels equal to those authorized for fiscal year 1974. It proposes to extend these programs for fiscal years 1976 and 1977 with substantive modifications, and extend, for fiscal year 1976, an existing program for the control of diseases borne by rodents. The reported bill would also authorize the establishment of new programs relating to home health services agencies, mental health of the elderly, epilepsy, Huntington's disease, and hemophilia. Existing programs revised and extended by this legislation include:

(1) *Health Revenue Sharing*.—Revises and extends existing section 314(d) of the Public Health Service Act (PHS Act) with a total authorization of \$240 million for fiscal years 1976 and 1977. Included in this authorization is a special authorization for establishing and maintaining programs for screening, detection, diagnosis, prevention and referral for treatment of hypertension.

(2) *Family Planning*.—Extends existing title X of the PHS Act with authorizations of \$378.5 million for fiscal years 1976 and 1977, and revises the authority by repealing the unused formula grant authority; by requiring that the research authority contained in title X, rather than general authorities of the PHS Act, be used for population research; by requiring annual updating of the five-year plan for family planning services; and by including in the law additional specifications with regard to family planning projects, entities eligible to apply for grants, and the extent of Federal participation in grants awarded for family planning projects and programs.

(3) *Community Mental Health Centers*.—Extends the Community Mental Health Centers Act with authorizations of \$217.5 million for fiscal years 1976 and 1977 and revises the Act to provide a new definition of and requirements for community mental health centers. The legislation consolidates the existing grant authority into grants for planning, grants for initial operation, grants for consultation and education services, conversion grants, financial distress grants, and grants for facilities assistance. The revised authority would also establish a National Center for the Prevention and Control of Rape within the National Institute of Mental Health to undertake a continuing study and investigation of rape, with authorizations of \$17 million for fiscal years 1976 and 1977.

(4) *Migrant Health*.—Amends section 319 of the PHS Act with authorizations of \$83 million for fiscal years 1976 and 1977 and amends the authority to define the nature, services, and operations of a migrant health center; establish a program of planning and development grants and grants for the costs of the operation of such centers;

require the Secretary to establish a National Advisory Council on Migrant Health; and require the Secretary to undertake a study of migrant housing.

(5) *Community Health Centers*.—Repeals existing section 314(e) of the PHS Act under which community health centers (also called neighborhood health centers) are now supported and establishes a new section 330 which defines the nature, services, and operations of community health centers; establishes a program of planning and development grants and grants for the costs of the operation of such centers; and authorizes \$460 million for fiscal years 1976 and 1977 for these purposes.

(6) *Rodent Control*.—Amends section 317 of the PHS Act to expand communicable disease control programs to include diseases borne by rodents. Rodent control programs have been supported since 1969 under section 314(e) of the PHS Act, which is repealed by this legislation. The reported bill would increase the fiscal 1976 authorization for section 317 to \$20 million.

New programs established by this legislation would—

(7) authorize demonstration grants for establishing and operating home health services agencies in areas in which such services are not now available and for the expansion of services provided by existing agencies. The bill would also authorize demonstration grants for training professional and paraprofessional personnel in the provision of home health care. Ten million dollars is authorized for fiscal year 1976 for these purposes.

(8) Establish a temporary Committee on Mental Health and Illness of the Elderly.

(9) Establish a Commission for the Control of Epilepsy.

(10) Establish a Commission for the Control of Huntington's Disease.

(11) Authorize projects to establish comprehensive hemophilia diagnostic and treatment centers and to develop and expand, within existing facilities, blood-separation centers. Sixteen million dollars is authorized for fiscal years 1976 and 1977 for these purposes.

BACKGROUND

The proposed legislation is virtually identical to the provisions of the conference report on H.R. 14214, which was pocket vetoed by the President on December 23, 1974, after the 93rd Congress had adjourned *sine die* except that authorization levels have been reduced in an effort to meet the President's objections.

During the 94th Congress, the Subcommittee on Public Health and Environment conducted six days of hearings on H.R. 11511, a similar predecessor to H.R. 14214, and, after consideration in executive session, reported H.R. 14214 as a clean bill to the Committee on Interstate and Foreign Commerce. On June 27, 1974, the bill was reported by voice vote of the full committee. H.R. 14214 passed the House of Representatives by a vote of 359-12 on August 12, 1974, and passed the Senate, as amended, on September 10. The conference report was agreed to on December 10 in the House by a vote of 372-14, but because the bill was not vetoed until December 23, there was no opportunity to attempt to override the veto.

On February 6, 1975, Representative Paul G. Rogers, Chairman of the Subcommittee on Health and the Environment and most Subcommittee members introduced H.R. 2954, which was identical to the vetoed bill. Hearings were conducted by the Subcommittee on February 19th. The bill was revised in Subcommittee executive session, reported by voice vote and reintroduced as a clean bill, H.R. 4925. The legislation was subsequently considered in open markup session by the full Committee on Interstate and Foreign Commerce and ordered reported, with amendments, by voice vote.

Similar legislation, S. 66, passed the Senate on April 10, 1975.

COMMITTEE RESPONSE TO ADMINISTRATION OBJECTIONS TO H.R. 4925

In the President's veto message, HEW Secretary Weinberger's testimony before the Subcommittee on Health and the Environment, and in a letter from Secretary Weinberger to the Chairman of the Committee, several objections are offered by the Administration to the provisions of H.R. 4925.

The objections raised by the Administration were carefully considered by the Committee during hearings and executive session.

The Committee is of the view that the objections overlook basic characteristics of the programs continued or proposed by H.R. 4925. However, in an effort to meet the President's objections with respect to funding levels, the Committee has substantially reduced authorizations from those proposed in the vetoed measure.

The principal objections to H.R. 4925 voiced by the Administration and the Committee's responses follow:

(1) *Selected communities receive grant funds under these authorities resulting in inequities on a national basis.*

In the Committee's view, the programs proposed in H.R. 4925 are aimed at correcting inequities—not causing them, as the Administration argues. The legislation is aimed at assisting communities and population groups which otherwise could not obtain needed health services. The real inequity in health is the fact that while some communities are rich in health services others can not even obtain basic care because services are not available. The community health centers, migrant health centers and family planning programs in fact are aimed at Americans who might otherwise be unable to secure adequate health care at all. Unfortunately, in recent years shortages of funds have prevented the start-up of enough migrant and community health centers to serve all of the populations in our nation who urgently need such services. Thus, the reported bill proposes to perfect and maintain existing centers and to move steadily ahead with the establishment of new services in areas of highest need.

(2) *Authorizations for grant programs in H.R. 4925 exceed, in many cases, the recommended appropriation levels in the President's budget.*

The Committee has adopted amendments to H.R. 4925 which seek to accommodate the Administration's objections. For fiscal year 1975, the Committee has adopted a simple extension of fiscal year 1974 authorizations. These authorizations are virtually identical to 1974 appropriations. Thus, for fiscal year 1975, the Committee is authorizing funding at levels consistent with 1974 appropriations levels. This is demonstrated in table 2, elsewhere in this report.

In response to the President's concern expressed in his veto message that these authorizations were excessive, the Committee has reduced what were previously considered reasonable figures by \$417 million. This reduction of approximately a quarter of the total amount means

that in some cases the increase in program funding is insufficient to even keep pace with current inflation rates.

(3) *The Community Mental Health Centers program has demonstrated the concept of community oriented mental health care delivery, and should be phased out as recommended in fiscal year 1976 rather than extended and strengthened as proposed in H.R. 4925.*

H.R. 4925 reaffirms the Committee's intent that the Community Mental Health Center program be continued and expanded until every community in our nation receives these services. The Administration continues to insist that this program is a "demonstration program," which should be phased out once it has shown that this new form of health services is effective. In fact, since the inception of the program in 1963, this Committee and the Congress have made it clear that seed money to establish community mental health centers should eventually be made available to every community in our nation. The Committee believes that the Administration's agreement that the CMHC concept is a successful approach to providing mental health services is, in fact, an argument promoting our original goal of a nationwide network of such centers. It continues to be this Committee's intent to provide the necessary Federal support to establish the approximately 1500 CMHCs needed to make mental health services available to every community in our nation. H.R. 4925 reaffirms the Committee's intent that this goal should be reached. The Committee sees no sense in cutting back existing CMHCs on the basis of the argument that we are being inequitable to those communities which have not yet been reached.

(4) *H.R. 4925 authorizes new programs, such as studies on mental health and illness of the elderly, epilepsy, and Huntington's disease, which are inconsistent with the President's commitment to veto new spending programs.*

H.R. 4925 does establish new programs such as studies on mental health and illness of the elderly, epilepsy, and Huntington's Disease, and grant programs for rape prevention and control, hemophilia services and home health services. The funding levels contemplated by this legislation for these new programs amount to only 3 percent of the total amount of funds authorized in this bill.

The studies of Huntington's disease and epilepsy by HEW and of the mental health problems of the elderly will provide future Congresses with a prospectus for meaningful Federal support in these areas.

The bill also contains a one year program of support for demonstration of home health agencies, a two year program of support for rape prevention and control programs in the National Institutes of Mental Health, and a two year program of support for blood separation and treatment centers for hemophilia. All three of these programs together involve less than \$45 million over the period of the bill. The committee believes these programs, while modest in terms of Federal expenditures, can have tremendous positive impact on vital areas of health care.

(5) *The legislation would repeal section 314(e) of the Public Health Service Act, a broad, general authority under which HEW has funded some of the programs proposed to be continued in this legislation. This*

would result in HEW's loss of the capability to operate special demonstrations or health services delivery programs.

The Committee's decision to repeal section 314(e) is based upon its belief that in recent years, the 314(e) authority has been used inappropriately by the Department of Health, Education, and Welfare. For example, the authority was used in recent years to fund substantial numbers of health maintenance organization projects without legislative guidelines, notwithstanding the fact that the health subcommittees in both the House and Senate were developing HMO legislation. In addition, on some occasions the Department has used the general authority available under 314(e) rather than requesting specific authority to support ongoing programs such as neighborhood health centers. Recent budget submissions have included requests to fund migrant health programs and family planning programs under 314(e) despite adequate legislative authority elsewhere.

In fact, legislation recently requested by the Administration (H.R. 4198, introduced by Mr. Staggers by request) proposes to amend section 314(e) to authorize appropriations of \$888 million for fiscal years 1975 and 1976 for programs for alcohol and drug abuse, migrant health, family planning, and services to meet health needs of limited geographic scope or specialized regional or national significance, and to make available "comprehensive health services (as defined by the Secretary)". Since a use of this general authority for the purposes noted above makes the authority difficult to oversee and makes its use unaccountable, the Committee has concluded that it is appropriate at this time to repeal it and replace it with specific new authorities for activities which the Committee feels need support.

COST OF LEGISLATION

As reported by the Committee, H.R. 4925 provides for a simple extension of fiscal 1974 authorizations for fiscal year 1975, and authorizations of appropriations for two additional fiscal years, 1976 and 1977, for health services programs at levels set forth in the following table.

TABLE 1.—NEW OBLIGATIONAL AUTHORITY FOR FISCAL YEARS 1975-77 UNDER H.R. 4925, AS REPORTED

[In millions of dollars]

Program	1975	1976	1977	Total
Title I:				
Health revenue sharing, total.....	(¹)	115	125	240.0
Comprehensive health services, sec. 314(d)(7)(A).....	(100)	(110)	(110)	(210.0)
Hypertension programs, sec. 314(d)(7)(B).....	(15)	(15)	(15)	(30.0)
Title II:				
Family planning programs, total.....	(¹)	171	207.5	378.5
Project grants and contracts, sec. 1001.....	(¹)	(110)	(140)	(250.0)
Training grants and contracts, sec. 1003.....	(¹)	(4)	(5)	(9.0)
Research grants and contracts, sec. 1004.....	(¹)	(55)	(60)	(115.0)
Information and educational materials, sec. 1005.....	(¹)	(2)	(2.5)	(4.5)
Title III:				
Community mental health centers, total.....	(¹)	103.75	113.75	217.5
Planning CMHC programs, sec. 202.....	(3.75)	(3.75)	(3.75)	(7.5)
Initial operation of CMHC's, sec. 203 ²	(50)	(55)	(55)	(105.0)
Consultation and education services, sec. 204.....	(10)	(15)	(15)	(25.0)
Conversion of CMHC's, sec. 205.....	(20)	(20)	(20)	(40.0)
Financial distress grants, sec. 213.....	(15)	(15)	(15)	(30.0)
Allotments to States for construction, sec. 228.....	(5)	(5)	(5)	(10.0)
Rape prevention and control, pt. D, total.....	7	10	10	17
Title IV:				
Migrant health centers, total.....	(¹)	39	44	83
Planning and development of MHC's, sec. 329(h)(1).....	(4)	(4)	(4)	(8)
Operating of MHC's, sec. 329(h)(2).....	(30)	(35)	(35)	(65.0)
Hospital services, sec. 329(h)(3).....	(5)	(5)	(5)	(10.0)
Title V:				
Community health centers, total.....	(¹)	220	240	460.0
Planning and development of CHC's, sec. 330(9)(1).....	(5)	(5)	(5)	(10.0)
Operating of CHC's, sec. 330(9)(2).....	(215)	(235)	(235)	(450.0)
Title VI:				
Diseases borne by rodents, sec. 601, total.....		20		20.0
Home health services, sec. 602, total.....		10		10.0
Demonstrations of establishment and initial operation of home health agencies.....		(8)	(-----)	(8.0)
Demonstrations of the training of personnel.....		(2)	(-----)	(2.0)
Committee on Mental Health and Illnesses of the Elderly, sec. 603, total.....				
Commission for Control of Epilepsy, sec. 604, total.....				
Commission for Control of Huntington's Disease, sec. 605, total.....				
Hemophilia programs, sec. 606, total.....		7	9	16.0
Treatment centers, sec. 1131.....		(3)	(4)	(7.0)
Blood separation centers, sec. 1132.....		(4)	(5)	(9.0)
Total.....		692.75	749.25	1,442.0

¹ One year extension at 1974 levels.

² Plus such sums as may be necessary for continuation grants.

These figures may be compared with recent budgetary experience in the six existing programs revised and extended by the proposed legislation (shown in the first two columns of table 2). They may also be compared with the figures included in the legislation as written in the last Congress and vetoed by President Ford (shown in the next

three columns of table 2). For ease of comparison the figures authorized by H.R. 4925 are summarized in the last three columns of table 2.

TABLE 2.—COMPARABLE OBLIGATIONAL AUTHORITIES FOR 1973-74 IN EXISTING LAW AND IN THE VETOED PROPOSAL FROM THE 93D CONGRESS

[In millions of dollars]

Program	Existing law		Proposed by 93d Congress (H.R. 14214) ¹			Proposed by H.R. 4925 ¹		
	1973	1974	1975	1976	Total	1976	1977	Total
Title I: Health revenue sharing.....	165.00	90.000	160.0	160	320.0	115.00	125.00	240.0
Title II: Family planning.....	201.75	118.024	215.5	257	472.5	171.00	207.50	378.5
Title III:								
Community mental health centers.....	349.00	197.605	139.0	164	303.0	103.75	113.75	217.5
Rape prevention and control.....			10.0	10	20.0	7.00	10.00	17.0
Title IV: Migrant health.....	30.00	26.750	75.0	80	155.0	39.00	44.00	83.0
Title V: Community health centers.....	157.00	230.700	260.0	280	540.0	220.00	240.00	460.0
Title VI (Miscellaneous):								
Diseases borne by rodents.....	14.00	14.000	15.0		15.0	20.00		20.0
Home health services.....				15	15.0	10.00		10.0
Committee on Mental Health and Illness of the Elderly.....								
Commission for Control of Epilepsy.....								
Commission for Control of Hunting- ton's Disease.....								
Hemophilia programs.....			8.0	10	18.0	7.00	9.0	16.0
Total.....	916.75	677.079	882.5	976	1,858.5	692.75	749.25	1,442.0

¹ H.R. 14214 in the 93d Congress revised and extended the programs through fiscal years 1975-76. Because fiscal 1975 is now almost over, H.R. 4925 delays the substantive revisions proposed by H.R. 4925 become effective beginning in fiscal year 1976.

COMMITTEE PROPOSAL

TITLE I—HEALTH REVENUE SHARING FOR COMPREHENSIVE PUBLIC HEALTH SERVICES

BACKGROUND

The first program of Federal health grants to the States was authorized in 1918 by the Chamberlain-Kuhn Act, but it was not until 1935 that legislation was enacted to provide Federal support on a continuing basis for State public health activities. Grants were made for general health services, tuberculosis control, cancer control, mental health services, dental services, radiological health services and home health services. One of the major limitations of this legislation was that funds appropriated for one category could not be transferred to another nor used to combat a public health problem outside the categories. This lack of flexibility conflicted with the growing potential of the States to improve and expand their public health activities.

To resolve this conflict, Congress passed the Comprehensive Health Planning and Public Health Service Amendments of 1966 (Public Law 89-749) which replaced the categorical grant authorities with five broad grant-in-aid programs. These five programs, incorporated in an amended section 314 of the Public Health Service Act (PHS), were designed to expand States' public health efforts and create a Federal-State-local "Partnership for Health".

Under the new subsection (d) of section 314 of the PHS Act, formula grants were to be awarded to State health and mental health authorities upon submission and approval of a plan for the provision of health services. Funds were no longer restricted to meeting specific disease problems. Rather, they were meant to offer the States flexibility in their use of the money, an opportunity to initiate new and different methods of providing health services where innovation was needed (particularly where existing State or local funds were inadequate to support new health services), and the chance to expand and improve previously established health services. The formula under which States were to receive 314(d) funds provided that the Federal share for each State would be based on that State's population and financial need. The Federal share ranged from 33⅓ per centum of the costs of eligible public health programs in States with the highest per capita income to 66⅔ per centum of the costs of such programs in those States with the lowest per capita income. At least 15 per centum of the funds allocated to a State were to be reserved for the State mental health authority to use for State and local mental health services. Public Law 89-749 authorized the first appropriation of funds under section 314(d) for the fiscal year ending June 30, 1968. In 1967

before any appropriations were made under Public Law 89-749, Congress passed the Partnership for Health Amendments of 1967 (Public Law 90-174) which extended section 314(d) until June 30, 1970, and provided a new, increased authorization for 1968. It also established a new requirement that at least 70 per centum of each State's allotments under section 314(d) (both the basic State allotment and the 15 per centum reserved for mental health) be used for actual services provided in the communities of the State. This requirement was included to insure that the funds provided under section 314(d) were for actual services rather than for other public health activities, such as planning, development, demonstration, and training, which were provided for by other authorities under section 314. In addition, Public Law 90-174 required that one per centum of the funds available be reserved by the Secretary of HEW for evaluation of the services funded, and made the Federal share of 66 $\frac{2}{3}$ per centum applicable to the Trust Territory of the Pacific Islands.

The new law did lead to rapid changes in State public health activities. New activities were initiated that would not have been possible under the former categorical programs or under State or local funding alone. This happened most often in instances in which support for projects to attack newly defined health problems or to carry out innovative health service activities were not authorized by State and/or local budgets. Many States which had been unable to use all of the categorical grant funding in the chronic disease areas began using unrestricted 314(d) funds to expand their existing public health programs.

By 1970, it was evident that many States were becoming more concerned with health systems and health service delivery methods than had been the case in the past. Almost without exception, the plans submitted by States described programs and services directed at particular populations rather than at particular diseases although concern for such major causes of death and disability as heart disease, cancer, diabetes, and stroke remained high priorities in some individual State programs.

Because authorizations under section 314(d) were due to expire at the end of fiscal year 1970, Congress included a provision in the Public Health Service Act Amendments of 1970 (Public Law 91-515) to extend section 314(d) and funding under it, to June 30, 1973. Under these amendments, States were also required to make their 314(d) plans compatible with their total Statewide health program, a requirement which was to have been achieved by assuring that 314(d) plans were consistent with general State health plans developed under section 314(a) of the PHS Act.

With the increased national concern that had developed about drug abuse and alcoholism, the State programs funded under 314(d) were turned to as a valuable vehicle for attacking the problem at the State and local level. The Drug Abuse Prevention and Control Act of 1970 (Public Law 91-513) required State plans under 314(d) to include provision of services for the prevention and treatment of drug abuse. This was followed by a requirement in the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment, and Rehabilitation Act of 1970 (Public Law 91-616) that State 314(d) plans provide for services for the prevention and treatment of alcohol abuse and alco-

holism, and by a further requirement in the Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) that the State plans provide for licensing of facilities for treatment and rehabilitation of persons with drug abuse and drug dependence problems and for expansion of State mental health programs and other prevention and treatment programs in the field of drug abuse and drug dependence.

Since 1972 States have used their 314(d) funds to provide ongoing health services to both the general population and to high-risk groups within the States. Services supported have been wide-ranging and have included communicable disease control, environmental services, chronic disease control, emergency and home health services, oral cancer and vision screening, and a variety of community mental health programs. Some States have used the flexibility of these funds to support new approaches to the delivery of these health programs; others have expanded into new areas of services for their State and local health agencies.

In fiscal year 1974 HEW obligated \$90 million in support of State and local health programs under section 314(d). This amount is a very small fraction of the total costs of public health programs. For example, it is estimated that the States and localities spent roughly \$1.7 billion of in non-Federal funds in fiscal 1974 on programs on alcoholism, cancer, chronic disease, communicable disease control, dental health, environmental health, heart disease, home health, and mental health. While the States activities in the area of health services have expanded considerably over the past several years, appropriations for these activities under 314(d) have remained constant through 1974. Table 3 below illustrates the budgetary history of section 314(d) since fiscal year 1970.

TABLE 3.—GRANTS FOR COMPREHENSIVE STATE PUBLIC HEALTH SERVICES, PHS ACT, SEC. 314(d)

[In millions of dollars]

Fiscal year	Authorization	Budget request	Appropriation	Obligation	Outlays
1970.....	100	72	90	89,673	85,190
1971.....	130	90	90	89,924	95,377
1972.....	145	90	90	89,180	81,658
1973.....	165	90	90	90,000	89,948
1974.....	90	90	90	90,000	(81,659)
1975.....	(¹)	67	90	(90,000)	(83,900)
Total, existing law.....	720	499	540	538,620	(517,732)
1976.....	100				
1977.....	110				
Total, H.R. 4925.....	210				

¹ H.R. 4925 provides for a simple extension of existing authority for fiscal year 1975. The program is presently being funded at the indicated level under continuing resolution.

While the flexibility of 314(d) funding has allowed the States to expand their health services activities, attack newly defined health problems, and carry out innovative health activities, it has made it very difficult to identify the accomplishments made by the States under 314(d) or evaluate the impact of such funds for the nation as a whole. There has been some effort to determine how 314(d) funds are actually spent and how effectively they have been used to improve

State and local public health efforts. The Department of Health, Education, and Welfare has contracted since 1970 with the Association of State and Territorial Health Officials (ASTHO) to develop a uniform health program reporting system for the States and Territories. The Committee wishes to emphasize that this project, which is still in a research and development stage but has been collecting data since 1972, should be supported and funded at an adequate level. The need for uniform public health program data will only increase as health planning and regulatory activities are implemented under the National Health Planning and Resources Development Act of 1974 (Public Law 93-641).

The Association of State and Territorial Health Officers is examining State health programs to determine program characteristics, populations served, services provided and resources expended. One of the difficulties in this process lies in the varying levels of sophistication with which States report their own spending of 314(d) funds, particularly in the handling of the 70 per centum of funds earmarked for use at the local level. There are several other factors which cloud an evaluation of the success of section 314(d) funding. The discretionary use of the money allows its expenditure on public health items for which other State or local funds cannot be used. These items may not relate to the most serious public health problems a State faces but rather to those elements in a comprehensive public health program which can be supported with no other funds. In other States the allocation of 314(d) funds is strongly affected by political considerations such as the relative popularity or visibility of a program and the expediency of tying it to State or local versus Federal funds.

Evaluating the benefits produced by 314(d) funds is also complicated by the effect of what is described as "accounting convenience" in the records of State public health programs. In actual practice this means that funds under 314(d) are at times allocated in a bookkeeping and recordkeeping sense to those programs to which it is simplest to allocate them. Thus, 314(d) funds may have allowed States to expand their public health efforts beyond those provided when only categorical aid was available but instead of describing the 314(d) dollars as supporting the new programs, 314(d) funds may be recorded as going to old projects previously paid for with State dollars, which are now free to be spent on new public health efforts. Because of these factors, it is presently difficult to evaluate not only how well the dollars have been spent, but often simply how they have been spent.

PROPOSED LEGISLATION

The proposed legislation extends section 314(d) with substantial modification for fiscal years 1976 and 1977. It authorizes a slight increase in current funding levels to enable the States to continue comprehensive public health services. It is also this Committee's intention that these funds can effect improved or expanded services.

STATE PLAN REQUIREMENTS

A significant change in existing law has been made by the committee with respect to requirements for State plans. The Committee has modified the State plan requirements contained in existing law to

make them consistent with provisions of the National Health Planning and Resources Development Act (Public Law 93-641). It is the opinion of the Committee that a requirement for submission of a separate plan for these public health funds would be duplicative and wasteful. Instead, the proposed legislation requires that the Secretary obtain through a uniform national reporting system an accounting of obligation or expenditures of Federal, State and local agencies for funding of public health services. It is the committee view that a review of actual expenditures will be more meaningful than a listing of anticipated spending. The committee continues to be impressed with the results of the Association of State and Territorial Health Officers Health Program Reporting System, presently being supported by HEW, which appears to be providing, for the first time, a measure of the impact of Federal funds upon the public health needs of our citizens.

STATE ASSURANCES

Before a State may receive a grant under the revised section 314(d), it will have to submit an application containing assurances that services will be provided in accordance with the applicable State health plan and that Federal funds will not be used to supplant non-Federal funds. States must also provide for necessary fiscal controls and accountability, uniform program reporting and the keeping of and authorizing access to such records as the Secretary may reasonably require.

MENTAL HEALTH

The proposed bill continues the existing requirement that 15 percent of the funds allotted to each State be devoted to the provision of mental health services.

It also requires that applicants provide assurances that the State mental health authority establish and carry out a plan designed to eliminate the inappropriate institutionalization of mental health patients.

While the Committee is encouraging the development of a better balance between community-based and institutional mental health care, it also recognizes that such adjustments may cause, directly or indirectly, some dislocation of public mental hospital employees. The Committee does not anticipate a widespread closure of public mental hospitals. However, the state plan requirement to reduce inappropriate institutional placement and the emphasis on outpatient center care as preferable to inpatient hospital care in the community mental health centers title, could, in a few instances, result in the closure, merger, or consolidation of hospitals, or in hospital staff reductions. In addition, there may be some instances of the transfer of the administration of a hospital from one employer to another (for example, from state to county government) in the interest of community-based mental health planning.

The Committee believes that individual employees adversely affected as a result of this bill should, whenever possible, be protected in a fair and equitable manner and that Federal funds or requirements should not be used directly or indirectly to weaken or undermine the legitimate interests and rights of the employees involved. For this reason, the Committee has included in the bill a provision designed

to assist public mental health employees. There is precedent for the principle of protecting employees affected by adjustments in an industry carried out under the aegis of Federal law. It exists in railway legislation, the Urban Mass Transportation Act and the Juvenile Justice and Delinquency Prevention Act.

The new provision requires that the State plan, which must be approved for States to receive funds, include fair and equitable arrangements to protect the interests of employees affected by actions taken pursuant to the plan. The Committee expects the Secretary to develop standards and criteria by which these plans may be so judged and approved. It is expected that the specific conditions for the protection of employees affected by actions taken pursuant to the State plan will be developed on a state-by-state basis as a result of negotiations between appropriate State authorities and employee representatives. The Committee also expects that, to the extent practicable, in carrying out his responsibilities with respect to this provision, the Secretary will rely on the expertise developed by the Department of Labor in connection with enforcing similar labor protective arrangements under other laws.

The provision specifies that arrangements must be made to preserve employee rights and benefits, and to provide appropriate training and retraining of persons who, as a result of implementation of a deinstitutionalization plan, are transferred to different employment. These rights and benefits should, where feasible, include collective bargaining rights, and such other existing rights and benefits as wages, hours, status, working conditions, pension benefits, seniority rights, vacation benefits, and other benefits which have been acquired through collective bargaining or otherwise.

Finally, it is the view of the Committee that, in implementing deinstitutionalization plans, States should attempt to place persons who lose employment in public mental health hospitals because of a shift in focus to community care in other available employment. Transfer of employees affected by deinstitutional plans to other State institutions is encouraged, as are good faith efforts to locate displaced employees in other occupations for which they may be qualified, such as employment in a community mental health center.

COMMUNITY SERVICES

The reported bill continued an existing requirement that no less than 70 percent of the allotments to States under the proposed section 314(d) (6) be spent in the provision of services at the community level. This provision is applicable to both mental health and general public health allotments.

AUTHORIZATIONS

The Committee has reduced its previously recommended authorization ceiling in H.R. 14214 for this program to \$100,000,000 for fiscal year 1976 and \$110,000,000 for fiscal year 1977. The Committee, however, does recommend an additional authorization of \$15,000,000 for fiscal year 1976 and \$15,000,000 for fiscal year 1977 for programs which will reduce the unnecessary toll of hypertension. Hypertension prevention programs yield great benefits in terms of reduced morbidity and mortality, and the Committee is convinced that additional efforts are imperative.

TITLE II.—FAMILY PLANNING

BACKGROUND

Until the 1960's, public attitudes towards family planning were characterized by ignorance or silence and family planning services were available only through private physicians and clinics. In recognition of this fact and of the role that birth spacing plays in prevention of birth defects and maternal illness, the broad authority of title V of the Social Security Act was used to Federally support family planning services for the poor. Low income individuals also received family planning services through the Economic Opportunity Act of 1964.

Neither of these legislative authorities, however, gave special emphasis to family planning nor was there any national focus until the passage of the Social Security Amendments of 1967 (Public Law 90-248), which included the Child Health Act of 1967, the first legislation to establish specific authority for family planning project grants. Furthermore, it stipulated that not less than six per centum of the funds appropriated for Maternal and Child Health under title V be obligated for family planning services. Shortly thereafter, the Economic Opportunity Amendments of 1968 established family planning as a special emphasis program of the Office of Economic Opportunity. The amendments to these Acts formed the basis for Federal policy with regard to family planning, a policy which emerged from the recognition of the health benefits associated with family planning services and the desire to provide expanded access to these benefits.

Federal activity in the area of population growth and control was focused in the Center for Population Research, established within the National Institute of Child Health and Human Development in 1968. The Center, with funds appropriated under section 301 of the PHS Act, sponsors research in contraceptive development, medical effects of contraceptives, human reproduction, and the social sciences including demography.

The growing Federal commitment toward direct provision of family planning services was embodied in the establishment, in October, 1969, of the National Center for Family Planning Services in HEW's Health Services and Mental Health Administration. The creation of the NCFPS, using funds appropriated under title V of the SSA, reaffirmed the Federal commitment that family planning services should be made available to those who, because of income or other circumstances, are denied access to such services.

In 1970, a major new Congressional initiative in the fields of population research and family planning was launched. The result was the passage of the Family Planning Services and Population Research Act of 1970 (Public Law 91-572)). The Act's intent was to greatly expand the availability of voluntary family planning services with priority on low income people. The Act of 1970 amended the PHS Act by adding to it a new title X which provided authority to the Secretary of HEW to award project grants and contracts to entities to establish and operate voluntary family planning projects. It also authorized a limited formula grant program to support the planning, establishment, maintenance, coordination and evaluation of family planning services offered by State health authorities although

funds have never been appropriated for this program. Training related to individual and State projects in family planning was provided for in a specific authorization. The grant and contract authority and authorizations for research in family planning and population was enlarged and new authority was provided for the development and distribution of informational and educational materials pertaining to family planning and population growth. Specific provisions were also included to insure that participation in family planning activities would be completely voluntary and that none of the funds appropriated under the title would support programs using abortion as a method of family planning.

The 1970 Act contained two other major provisions: one authorizing the establishment of an Office of Population Affairs within HEW to be headed by a newly created and appointed Deputy Assistant Secretary for Population Affairs, and the other the formulation by HEW of a five-year plan for accomplishing the objectives. The five-year plan was to include an indication of the number of individuals to be served by Federal family planning programs, the type of informational and educational material to be developed, plans for its distribution, the focus and objectives of Federally supported population research and training to be supported, and an estimate of the costs and personnel requirements needed to meet the objectives of the Act. A provision was also included calling for the establishment of a reporting system for gathering comprehensive data on family planning services administered or supported by HEW which could serve as the basis for HEW's evaluation of the family planning services being provided.

Each year for the five years following formulation of this plan, the Secretary was required to submit a report to Congress. Each report was to include a comparison of the results achieved in the preceding year in fulfilling the objectives of the plan and was to indicate the steps projected for implementing the plan in its remaining years. The Secretary was also to report on revisions in the plan and to make recommendations for additional legislative or administrative action necessary for carrying out the plan.

The first funds to be appropriated under title X of the PHS Act became available in fiscal 1971 although regulations governing project grants were not published until September 1971. The appropriation was small, less than one-tenth the amount authorized, and served primarily as developmental money for a limited number of project grants. In October, 1971, the five-year plan was submitted providing the basis for directing the pattern of support to various project approaches.

With an appropriation ten times that of the preceding year, it was possible in fiscal 1972 to begin widespread support for family planning services. Administrative authority for distributing this funding was vested in the National Center for Family Planning Services. Revised regulations governing project grants and new regulations for training grants were also published in 1972. As a result of these developments, by the end of fiscal 1972, 271 projects were being funded with monies authorized under title X. These increases took place, in

part, as family planning services under title V of the Social Security Act decreased.

Since 1972, appropriations have continued to increase, resulting in continued growth of the number of programs and clinics supported by HEW. Most of the increase has been due to the administrative transfer of family planning projects funded under the Office of Economic Opportunity's special program to HEW. Since 1972, many OEO family planning projects have come under the administration of HEW and the funding for these projects appropriated under title X instead of the Economic Opportunity Act. Table 4 provides a budget history of title X.

TABLE 4.—FAMILY PLANNING SERVICES, PHS ACT, TITLE X

[In millions of dollars]

Fiscal year and grant program	Authori- zation	Budget request	Appropria- tion	Obliga- tion	Outlays
1971:					
Project grants, sec. 1001.....	30.000	¹ 6.000	6.000	0	0
State formula grants, sec. 1002.....	10.000	0	0	0	0
Training, sec. 1003.....	2.000	0	0	0	0
Research, sec. 1004 ²	30.000	0	0	0	0
Information and education, sec. 1005.....	.750	0	0	0	0
Total.....	72.750	6.000	6.000	0	0
1972:					
Project grants, sec. 1001.....	60.000	55.500	55.500	61.467	15.844
State formula grants, sec. 1002.....	15.000	0	0	0	0
Training, sec. 1003.....	3.000	3.000	3.000	2.988	.17
Research, sec. 1004 ²	50.000	2.515	2.615	2.586	.287
Information and education, sec. 1005.....	1.000	.700	.700	.686	.50
Total.....	129.000	61.815	61.815	67.727	16.198
1973:					
Project grants, sec. 1001.....	111.500	111.500	111.500	79.500	87.570
State formula grants, sec. 1002.....	20.000	0	0	0	0
Training, sec. 1003.....	4.000	3.000	3.000	2.991	2.536
Research, sec. 1004.....	65.000	2.615	2.615	2.507	3.054
Information and education, sec. 1005.....	1.250	.909	.909	.600	.347
Total.....	201.750	118.024	118.024	85.565	93.507
1974:					
Project grants, sec. 1001.....	111.500	³ 124.909	94.500	³ (124.909)	-----
State formula grants, sec. 1002.....	0	0	0	0	-----
Training, sec. 1003.....	3.000	3.000	3.000	(3.000)	-----
Research, sec. 1004 ²	2.615	2.515	2.515	(2.515)	-----
Information and education, sec. 1005.....	.909	.600	.600	(.600)	-----
Total.....	118.024	³ 131.024	100.651	³ (131.024)	(124,684)
1975:					
Project grants, sec. 1001.....	111.500	94.000	94.500	(94.500)	-----
State formula grants, sec. 1002.....	0	0	0	0	-----
Training, sec. 1003.....	3.000	3.000	3.000	(3.000)	-----
Research, sec. 1004 ²	2.615	2.515	2.515	(2.515)	-----
Information and education, sec. 1005.....	.909	.600	.600	(.600)	-----
Total.....	⁴ 118.024	100.115	⁴ 100.615	(100.615)	(103,439)
Total existing law.....	639.548	417.478	387.069	(384.931)	(337,828)
1976:					
Project grants, sec. 1001.....	110.000	-----	-----	-----	-----
State formula grants, sec. 1002.....	0	-----	-----	-----	-----
Training, sec. 1003.....	4.000	-----	-----	-----	-----
Research, sec. 1004 ²	55.000	-----	-----	-----	-----
Information and education, sec. 1005.....	2.000	-----	-----	-----	-----
Total.....	171.000	-----	-----	-----	-----

TABLE 4.—FAMILY PLANNING SERVICES, PHS ACT, TITLE X

[In millions of dollars]

Fiscal year and grant program	Authori- zation	Budget request	Appropri- ation	Obliga- tion	Outlay
1977:					
Project grants, sec. 1001	140.000	-----	-----	-----	-----
State formula grants, sec. 1002	0	-----	-----	-----	-----
Training, sec. 1003	5.000	-----	-----	-----	-----
Research, sec. 1004 ²	60.000	-----	-----	-----	-----
Information and education, sec. 1005	2.500	-----	-----	-----	-----
Total	207.500	-----	-----	-----	-----
Total H.R. 4925	348.500	-----	-----	-----	-----

¹ Supplemental appropriation requested with availability until the end of fiscal year 1972.² Sec. 1004 funds have not been used to support basic research on family planning and population growth. Funds authority under the broader authority of Public Health Service Act sec. 301 have been used for this purpose and are referenced in related obligations, National Institutes of Child Health and Human Development.³ Includes \$30,409,000 of released, impounded 1973 money.⁴ H.R. 4925 provides for a simple extension of existing authority for fiscal year 1975. The title is presently being funded at the indicated level under continuing resolution.

FAMILY PLANNING SERVICES, RELATED OBLIGATIONS

[In millions of dollars]

Fiscal year	Social Security Act title V project grants for services	Office of Economic Opportunity	National Institutes of Child Health and Human Development, PHS Act, sec. 301	Total
1971	31,285	23,800	28,400	103,485
1972	27,000	24,000	40,000	91,000
1973	19,000	15,000	39,800	73,800
1974	19,000	-----	51,400	70,400

In fiscal 1973, about 400 family planning services project grants and approximately 3300 clinics were supported by funds authorized under section 1001 of the PHS Act. These project grant funds subsidized services to an estimated 1.6 million women, up from 860,000 in fiscal 1971 and 1.05 million in fiscal 1972. By the end of fiscal year 1975, 300 project grants supporting over 3600 clinics will be providing services to more than two million women. The decrease in the number of project grants between fiscal 1973 and fiscal 1974 is due to the HEW policy of consolidating several small clinics under one grant. The grantee is generally a public or private, State-wide or sub-state coordinating agency, with which the individual clinics contract to provide services in their localities.

The individual projects receiving support vary considerably in the number of clinics they contract with and in the size and characteristics of the population and geographic areas they serve. Programs offer both social services and medical services. The social services include counseling which is often based on the informational and educational materials prepared by HEW under section 1005 of the PHS Act. The medical services provided include general medical examinations, pelvic and breast examinations, pap smears and other diagnostic laboratory tests, as well as the provision of infertility services and contraceptives. In addition to being of specific utility in dealing with the medical aspects of family planning, the medical services provided are of major value as a source of preventive health care for women of childbearing age.

As family planning centers have developed and become fully operational, the cost per patient visit has been reduced, further optimizing the benefits obtained from funds provided to individual projects. While family planning services have continued to expand and demonstrate their effectiveness and value, it appears that certain population groups requiring these services are not yet being reached. These groups include teenagers, especially males, the emotionally handicapped, institutionalized individuals, and American Indians. The problem of reaching these individuals is being studied with operational research funds and is also approached by way of various educational programs. The success of these efforts promises to further enhance the availability of family planning services to many individuals previously unserved in all regions of the country.

The broad authority for family planning services contained in title X is designed to insure that these services are available to persons of all incomes who would not otherwise be able to obtain them. Because family planning services have been particularly inaccessible to low-income women, specific supplementary supports have been made available to projects serving this population. Most recently the Congress has emphasized its interest in making family planning services available to low-income families through passage of amendments to title IV-A, Aid to Families with Dependent Children (AFDC), and title XIX of the Social Security Act. These changes, contained in the Social Security Amendments of 1972 (Public Law 92-603), make it mandatory under title IV-A for States to provide voluntary family planning services to AFDC recipients who are of childbearing age; they increase the Federal matching share under title IV-A; and they make family planning a mandatory benefit and increase the Federal matching rate for family planning services under title XIX. Title XX of the Social Security Amendments of 1974 (Public Law 93-647) extended eligibility to persons in need of family planning services by permitting States to expand these services to population groups other than those who are "categorically related" i.e., are aged, blind, disabled or are receiving AFDC payments. This will permit Federally reimbursable coverage to young married persons, to the near poor and to single persons. The 90 percent Federal matching share is retained for these programs as is the mandatory requirement for the provision of family planning services.

Section 1004 of title X provides specific authorization for appropriations to promote and support research in the biomedical, contraceptive development, behavioral and program implementation fields related to family planning and population policy. General authority for conducting biomedical research on family planning and population growth was already contained in section 301 of the PHS Act when title X was added to this Act. HEW chose to use the appropriations made under section 1004 only for delivery oriented, or operations, research. This is research of an evaluational nature so that rather than increasing basic information about population growth and the biomedical aspects of family planning, it focuses on modes of operation and administration of services and on methods of planning service programs. Contrary to Committee intent, the other family planning and population research which could have been carried out under section 1004, has instead been conducted through the National In-

stitutes of Child Health and Human Development using funds available under section 301 of the PHS Act.

One of the factors contributing to the success of the Federal family planning program has been the Five Year Plan called for by the 1970 Act. This Plan and the annual reports submitted to Congress outlining progress toward filling its objectives have made evaluation of existing policies and practices in the field, and determination of the need for new ones possible. However, the committee wishes to note with dissatisfaction that the Plan and reports have lacked the information needed to delineate the actual measures to be taken to fulfill the Plan's objectives, and have always been late. The reports have also failed to specify what new initiatives are planned to provide services to the large number of low and marginal income families presently unable to obtain such services.

Another area of difficulty in Federal support for family planning services comes from a new emphasis on third-party payments for services received. While it is certainly reasonable and desirable to obtain all third party reimbursements appropriate for services provided, there is the danger that financial policies formulated to insure such reimbursements will inadvertently limit the provision of subsidized family planning services to only those persons receiving public assistance under Medicaid. Such a fiscal policy, should it emerge, would restrict services to only certain low-income persons whereas the legislation requires that priority be given to all low-income persons.

An issue which recently raised considerable controversy was the issue of informed consent in connection with sterilization procedures. The title X regulations require that all methods of contraception be offered in family planning clinics, and medical opinion supports vasectomies and tubal ligations as safe, effective contraceptive procedures. New regulations, issued by HEW in response to a recent decision by the U.S. District Court for the District of Columbia, require that projects using Federal funds for nontherapeutic sterilizations instruct legally competent candidates for the procedure as to the full nature of the operation, its irreversibility and side effects, and specifically inform them in writing that a decision not to be sterilized will not result in the denial or withdrawal of any other benefits to which the candidate is entitled. Guidelines establishing a moratorium on Federal support for sterilization of persons under 21, or otherwise legally incapable of giving informed consent, remain in effect under the current regulations.

Another policy which has given rise to concern in some sectors is that of consolidation of small grants under one "umbrella" grantee, mentioned above. This policy evolved with the transfer of many small OEO clinics to HEW, and was an attempt to streamline the management of the clinics and to reduce costs. In most cases, clinics were consolidated under the existing HEW grantees, which were either health departments or private nonprofit coordinating councils. With the completion of the OEO transfers during fiscal 1974, no further consolidation is contemplated by HEW. There will, however, be continued efforts to introduce and maintain comprehensive family planning services in other health care settings such as neighborhood health and migrant health centers. This move was initiated, in keep-

ing with the intent of the legislation to make family planning services widely available, because it was felt that other ambulatory health service programs funded by HEW did not provide a sufficient range of family planning medical and social services to their clients. The new policy also highlights the preventive health nature of family planning services and the value of such services as an integral part of ambulatory health care.

PROPOSED LEGISLATION

In considering the family planning program conducted under the 1970 Act, the Committee was generally impressed with its accomplishments. Several sections of the present law were viewed as needing strengthening and clarification however, and are therefore amended substantially. The increased authorizations, amendments, and other Committee concerns are discussed below.

Increases in Authorizations

The extension of the family planning services projects grant program indicates the high regard with which the Committee views the accomplishments of this program. Project grant funds have assisted in providing approximately half of the cost of the family planning services provided to the more than 3 million women in the United States who receive family planning services from organized programs.

The Committee has authorized \$110 million for fiscal 1976 and \$140 million for fiscal 1977 for the continuation and expansion of the family planning services program under the Act. The Committee has provided this additional authority so that the project grant mechanism may be used to support services for an additional 330,000 patients in fiscal year 1976 and 530,000 patients in fiscal year 1977 bringing the total number of people served by organized programs and other resources, assuming current levels of commitments are maintained, to 4 million by the end of fiscal 1977.

The Five Year Plan for carrying out the mandate of the 1970 Act estimated needed Federal expenditures for population research at \$75 million for fiscal 1973, \$100 million for fiscal 1974, and \$125 million for fiscal 1975. However, due to budget stringencies and executive impoundment of funds, the program has consistently remained at the fiscal 1972 funding level of about \$40 million until this year. The Committee has thus been forced to revise authorization levels for the research program in order to reflect the present capacity of the field to expand and absorb increased funds over the next two fiscal years. The Committee believes that \$55 million can be used wisely and effectively in fiscal 1976 and proposes to increase this authorization to \$60 million for fiscal 1977.

Amendments to Research Authority

The existing law provides authority for the Secretary to make grants and contracts for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

However, appropriations in the past under this section have provided for support of only operational research activities in the field of family planning. Population research has been conducted, directly

and through contracts and grants, by the Center for Population Research in the National Institute of Child Health and Human Development. Research areas with which the Center is concerned are development and medical evaluation of contraceptives, human and animal reproductive biology, behavioral sciences, and social sciences, including demography. Appropriations for these activities have been made under the general authority provided by section 301 of the PHS Act, rather than the specific authority of section 1004 of title X. They have been conducted within the facilities of the National Institutes of Health and by grants and contracts to universities, research institutions, and other private or public entities.

The amended section 1004 clarifies earlier Congressional intent to provide specific funding under title X of the PHS Act to study biomedical and behavioral aspects of population and population growth; to investigate new contraceptive drugs and devices; and to conduct operational research as it relates to the implementation of family planning service programs. Thus, a specific requirement has been added to section 1004 that it, rather than 301, be used for all family planning research in order to increase program accountability and encourage program growth. Recognizing that, with the exception of family planning operational research, much of the authorized population research is conducted by scientists in the facilities of the National Institutes of Health, the Committee has provided new authority for the Secretary to conduct research as well as make grants and enter into contracts with public or private entities and individuals to conduct such research.

While population research and family planning services research will continue to be the responsibility of the Center for Population Research and the Health Services Administration respectively, the Deputy Assistant Secretary for Population Affairs will continue to coordinate these activities and will report, through the Secretary, to Congress on the results of these activities.

Family Planning Five Year Plan

The Family Planning and Population Research Act of 1970 called for the development of a plan, which would set forth the objectives of the Federal population research and family planning programs for the next five years and indications of the manner in which the objectives would be achieved on a phased basis. The Act provided that the plan would be submitted to Congress six months after enactment, and that progress reports on achievements would be made on or before January 1 thereafter for five years. The Committee has repealed this section and amended the law to provide that a report and an updated five year plan be submitted within four months after the end of each fiscal year. Planning should be a continuous process especially in the rapidly changing fields of population research and family planning. Thus, a continuous updating and revision of a plan is more realistic than developing one at the beginning of a five year period and leaving it unchanged. The plan should take into account the prevailing and anticipated role of family planning within the context of the health delivery system, and should reflect the prevailing and anticipated changes in the state of the art regarding behavioral, biomedical and social research on population. The Committee recognizes that public attitudes toward family planning have changed

measurably since the enactment of the Family Planning and Population Research Act of 1970, understands that these attitudinal differences are due in large part to the Federal activities authorized by the Act, and feels that these changes should be reflected in the plan.

The Committee recognizes that the bill provides authorizations of appropriations only through fiscal year 1977 and that the plan called for covers a five year span. Thus, the span should be specific for the years in which the authorizations apply and general thereafter. The latter portion should present alternatives for the formulation of sound policy in the fields of family planning and population research with suggested authorizations of appropriations for those alternatives. It is not the intent of the present bill to set up a planning process in which measurement of success will be simple statistics on numbers of people served. There should be a substantive status report with comparisons of achievements against objectives established for the fiscal year in question. Should objectives change between the time the plan was drafted and the time the report is developed, such changes and the reasons therefor should be explained.

Informed Consent

The Committee continues to require that participation by any individual in the program is to be voluntary and free of compulsion or coercion of any kind, and that no person will be required to receive family planning services or information under the Act as a prerequisite to eligibility for or receipt of any other Federal or local services, assistance, or information. The Committee believes that appropriate informed consent should be obtained from all people and that the basic elements of informed consent shall include (1) a fair explanation of the procedures to be followed, including an identification of any which are experimental; (2) a description of any attendant discomforts or risks which might reasonably be expected; (3) a fair explanation of the likely results should the procedure fail; (4) a description of any benefits which might reasonably be expected; (5) a disclosure of any appropriate alternative methods or procedures that might be advantageous; (6) an offer to answer any inquiries concerning the procedures; and (7) an instruction that the subject is free either to decline entrance into a project or to withdraw his consent and to discontinue participation in the project or activity at any time without prejudicing his future participation.

Grant Consolidation

The original title X legislation authorized two funding mechanisms for the support of family planning programs: a project grant program of direct assistance to local public and private nonprofit agencies and a program of grants to state health agencies, on a formula basis, to enable them to assist local programs in planning for and delivering family planning services. HEW did not request any funds for the formula grant authority in its first three years and, accordingly, the Congress let the authority lapse in the Public Health Services Extension Act of 1973. Few state health agencies have made substantial progress in assuming a stronger role in the provision of effective administrative, planning and technical assistance support to local programs. The number of full-time state health agency administrative personnel assigned to family planning has remained almost constant

for the past three years and is far below what the HEW Five Year Plan itself indicates is necessary.

In extending the project grant program, the Committee believes HEW must continue to have direct responsibility for the monitoring of local projects, the provision of technical assistance and training, as needed, and the allocation of resources between projects. Despite the fact that HEW does not plan any further consolidation of grants, it is recognized that, in some instances, it may be necessary for administrative reasons for HEW to encourage or even require that local grantees consolidate their grant applications, although it is not the Committee's intent that consolidation be used to transfer program management responsibility from the Federal to the State or lower level. Nor should this process remove local projects from participation in the National and State decisionmaking process for family planning services policies. When the consolidation of project grants is undertaken, it is imperative that the consolidation take place at the local community level, that no single agency be in a position to determine or unduly influence the allocation of resources to other potential family planning providers, that all potential providers be able to participate in the basic policies governing the implementation of the grant, and that HEW provide adequate resources to foster a meaningful, programmatic consolidation and coordination. Further, under the provisions of this bill, no project shall be denied the right to apply for and receive an individual grant or contract despite other consolidation efforts. A systematic attempt by HEW to consolidate local project grants under the control of state agencies and shift a large part of the administrative responsibilities and decisions as to resource allocations to these state agencies would be contrary to the intent of the law. To guarantee that the intent of the law is carried out, the Committee has added specific language which requires that the Secretary guarantee the right of each applicant to direct access to the Federal funding agency. When consolidation is deemed desirable, the eligible public and private agencies must have the opportunity to jointly determine the policies, priorities and allocation of resources within the project or program.

Program Staffing

The Committee believes that the reorganization of health services programs which has resulted in the dissolution of specialized agencies and staff for family planning both at the national and regional levels makes it extremely difficult for the program to maintain the accountability to the Congress which is required by law. The existence of the post of Deputy Assistant Secretary for Population Affairs and the Office of Population Affairs in the Office of the Assistant Secretary for Health, which is mandated by law, has been instrumental in maintaining some accountability for the program, although the absence of a nucleus of specialized personnel both at the national and regional levels has overburdened that office. An April 15 GAO report indicates that, contrary to the intent of the law in creating the post of Deputy Assistant Secretary for Population Affairs, and the Office of Population Affairs, the Federally assisted family planning programs, particularly those administered by the Social and Rehabilitation Service have operated independently of, and often in policy conflict with each other. It is imperative, therefore, that the Deputy Assistant Sec-

retary for Population Affairs receive the full support of the Office of the Secretary in implementing the line authority and coordinating responsibility mandated under this Act. In addition, HEW must take the necessary steps to provide specialized personnel for adequate administration and supervision of the family planning programs at both Federal and Regional levels. In view of the scope of the family planning grant activities, a minimum of three program specialists, including one senior grade person, should be assigned in each region to guarantee the accountability of the program. Such staff should be increased, as required, to reflect the greater demands of individual regions.

National Reporting System for Family Planning Services

The Committee has added language to the law mandating the continuation and improvement of the National Reporting System for Family Planning Services. The existence of this reporting system has facilitated program development and management, and made it possible to monitor the types and amounts of services rendered and the financial and social characteristics of people served. The purpose of the System is twofold: to provide national statistical data for Federal managers and Congressional use and to provide statistical data for clinic and grantee management and self-evaluation. The Committee recognizes that past difficulties with the system may stem from trying to develop one system to serve the diverse needs of local projects and national planners including the Congress. Thus, HEW is urged to make such modifications that may be necessary for these purposes and to provide the resources to finance them. It is imperative for the Secretary to mandate that other departmental reporting systems for family planning services (such as Medicaid and title IV-A family planning services) be developed and conformed to the national statistical system. In spite of the existence of the National Reporting System, HEW has yet to develop an agency-wide system which is capable of providing the Congress with unduplicated counts of services given and accurate expenditure reports.

Economic Nondiscrimination

It is the Committee's belief that the benefits of family planning to both individuals and to our society warrant a program approach which guarantees that a person's economic status shall not be a deterrent to obtaining and utilizing services. The Committee has added language to express this intent, as there is evidence that HEW has occasionally adopted a contrary approach. While the Committee supports a genuine effort to strengthen the participation of Medicaid and other third-party reimbursement mechanisms in the financing of family planning and other health programs, the current financial policies pursued by the Department could limit the provision of subsidized family planning services to public assistance and Medicaid recipients. Such a policy would make it impossible for family planning to assist individuals and couples to avoid the dependency that often results from involuntary pregnancy. The federal family planning effort must serve not only the poorest individuals but all persons who for economic or other reasons have difficulty in obtaining the services they need and want. On the other hand, the Committee sees great value in having family planning projects carry out their activities with an in-

creasing degree of independence from direct Federal support. Accordingly, the Committee wishes to see projects continue to actively seek reimbursement for the services they perform, and the contractual mechanisms developed under Title IV-A of the Social Security Act maintained. In all cases the Committee intends that projects be reimbursed for the fair value and cost of these services regardless of the Federal project grant support received by the project. Any other determination of a lower reimbursement level by States or the Secretary would be directly contradictory to the Secretary's expressed objective of decreasing project dependence on Federal grant funding and is contrary to the expressed intent of the Committee.

Section 204(d) of the bill amends section 1006(c) of the PHS Act by adding emphasis to the requirement of the present Act that priority in services should be given to persons from low income families. Family planning services are vital preventive health services and, though widely available to the majority of Americans who are not poor, may not be accessible to economically less fortunate individuals. Family planning services, as defined in this bill, must be made available through a variety of delivery systems designed to serve low income people. The Committee encourages the use of funds authorized by this bill for the provision of services, not only in specialty clinics, but, where such facilities do not exist or are impractical, in entities devoted to comprehensive health care for low income families. In keeping with the Committee's intent, the Secretary is urged to revise the current income levels set in the Department's regulations in 1972 to reflect the current economic indices of poverty.

TITLE III.—COMMUNITY MENTAL HEALTH CENTERS

LEGISLATIVE BACKGROUND

In October 1963, Congress approved and sent to President Kennedy legislation authorizing limited Federal financial assistance for the States to aid them in the construction of community-based mental health centers. Such centers, the Congress believed, could be more effective in dealing with the problems of treating the mentally ill than the institutional programs of State and county mental health hospitals scattered across the United States. It was hoped that community-based treatment programs would replace large institutions as the locus for dealing with the mental health problems of the country:

Either we must develop the quantity and quality of community services which will ultimately replace these institutions or we will have to undertake a massive program to strengthen the State mental hospitals. The committee believes that the development of new methods of treatment, the impressive evidence of the possibilities for rehabilitating the mentally ill, and a lessening of our disposition to reject and isolate sufferers, all argue strongly for the treatment of mental illness in the community.¹

¹ House Report No. 604, 88th Cong., 1st sess.; Aug. 21, 1963.

As approved by the President, the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (Public Law 88-164) entitled each of the States to an allotment of Federal funds on the basis of three considerations: (1) population, (2) the extent of facility need, and (3) the overall financial need of the respective States. Each State was required to develop a comprehensive mental health plan together with a list of priorities for action regarding the mental health activities proposed by the State. States were also required to provide assurances that the services of centers would be available to all and that a reasonable amount of care would be provided to indigent persons.

The original Act authorized a total of \$150 million in construction funds for the fiscal years 1965, 1966 and 1967.²

The 1965 Amendments

In his 1963 message to Congress on mental illness and retardation, President Kennedy had asked for funds for the purpose of making short-term grants to help meet the costs of initial staffing for community mental health centers (CMHCs). Though such authority was included in the Senate-passed bill, it was deleted from the legislation finally enacted by Congress and signed into law by the President. In January 1965, President Johnson asked the Congress to reconsider legislation to help finance a portion of the costs of initial staffing:

An important beginning toward community preparation has been made through the legislation enacted by the 88th Congress authorizing aid for constructing community mental health centers. But facilities alone cannot assure services. . . . I therefore recommend legislation to authorize a 5-year program of grants for the initial costs of personnel to man community mental health centers which offer comprehensive services.³

In response to this request, Congress passed the Community Mental Health Centers Construction Act Amendments of 1965 (P.L. 89-105). Under the legislation, grant funds were available for the initial staffing costs for professional and technical personnel incurred by centers constructed under the 1963 program and similar costs for centers already in existence which were proposing to add new or additional mental health services to their programs. The legislative history makes it clear that Congress intended such assistance to be limited in scope and brief in duration:

It is not the intention of the committee that the Federal Government will assume the traditional responsibility of the States in this field. However, it is the committee's considered view that it is the proper role of the Federal Government to give its financial assistance in this transitional period.⁴

To achieve this objective, grants were authorized on a decreasing matching basis for a period of 51 months.

² Authorizations and appropriations for the community mental health centers program are discussed in the next section of this report.

³ "Advancing the Nation's Health," Special Message to the Congress, Jan. 7, 1965.

⁴ Senate Report No. 366, 89th Cong., 1st sess., June 24, 1965.

The 1965 Amendments authorized staffing funds amounting to a total of \$73.5 million for fiscal years 1966-1968.

The 1967 Amendments

In June 1967, Congress again amended the CMHC program by enacting the Mental Health Amendments of 1967 (Public Law 90-31). The legislation extended the authorizations for the construction and initial staffing grant programs already enacted and amended the definition of the term "construction" to permit the acquisition of existing buildings for use as CMHCs.

The 1967 Amendments authorized construction funds totalling \$180 million for fiscal years 1968-1970, and an additional \$58 million for initial staffing grants for the same period.

The 1968 Amendments

In October 1968, the scope and purposes of the Community Mental Health Centers Act was broadened by adding new programs of construction and initial staffing assistance for centers and other specialized facilities for the treatment of alcoholism and narcotic addiction. Under the Alcoholic and Narcotic Addict Rehabilitation Amendments of 1968 (Public Law 90-574), facilities were entitled to grant assistance in amounts not to exceed two-thirds of the costs of facility construction. Staffing grants were also available on a declining Federal share basis. Congress also authorized States (subject to a "maintenance of fiscal effort" provision) to use 2 percent of their allotment funds (not to exceed \$50,000) to meet the costs of program administration.

The 1968 Amendments authorized a total of \$40 million for the two fiscal year period, 1969 to 1970, for the various construction, staffing, training and evaluation programs included in the Alcoholic and Narcotic Addict Rehabilitation Amendments.

The 1970 Amendments

Originally, the CMHC program had been designed to provide basic "seed" money for the purposes of constructing community facilities and to help centers meet their initial costs of operation. But in 1970, Congress concluded that additional financial support would be needed to promote and continue the development of center programs throughout the United States. State and local sources of funding proved to be inadequate.

Earlier optimism regarding the progressive development of funding resources through Federal health insurance and medical assistance programs, private insurance plans, and other third-party payments proved too optimistic . . . During the early years of the program, it has become increasingly clear that the localities in the greatest need of community-based mental health services, the urban and rural communities of low economic status, have been least able to organize, plan and raise sufficient funds to develop programs eligible for Federal grant support.⁵

Under the Community Mental Health Centers Amendments of 1970 (Public Law 91-211), the Federal share of the costs of center construction was increased. The declining Federal matching formula

⁵ House Report No. 91-735, 91st Congress, 1st Session ; December 10, 1969.

used to determine the share of staffing was also changed. Centers not in poverty areas were now entitled to grants over an 8 year period (rather than for 51 months) at the new rates shown in the following table. Centers located in poverty areas received assistance for the same period of time (8 years), but at the more favorable rate shown in the table. The ratios also applied to facilities serving alcoholics and narcotic addicts.

TABLE 5.—AUTHORIZED MAXIMUM FEDERAL MATCHING SHARES

[In percent]

	Year							
	1	2	3	4	5	6	7	8
Nonpoverty area.....	75	75	60	45	30	30	30	30
Poverty area.....	90	90	80	75	75	70	70	70

A number of other changes were made by the 1970 Amendments. The percentage of State allotments authorized to meet administrative costs was raised from 2 to 5 percent, although the overall limit of \$50,000 was retained. A new program of initiation grants was added for the purpose of assessing local needs for mental health services, designing center programs, developing services and for other purposes. A new program for children's mental health services was incorporated into the Act, including construction and staffing assistance and grants for training and evaluation purposes. Also added was a program of direct grants for special projects relating to alcoholism and narcotic addiction. Funds were authorized for consultation services provided in centers and specialized treatment facilities.

The 1970 Amendments authorized \$270 million for center construction and \$155 million for initial staffing purposes for fiscal years 1971-1973. Initiation grants were to be funded from appropriations authorized for staffing grants. The alcoholic and narcotic addict rehabilitation and treatment programs were also extended for the same duration with authorizations amounting to \$105 million. The new children's mental health services program contained authorizations totaling \$62 million, while \$15 million was provided to meet the costs of consultation services.

Related Drug Abuse and Alcoholism Amendments

Two other laws enacted by Congress in 1970 amended programs included in the Community Mental Health Centers Act. The Comprehensive Drug Abuse Prevention and Control Act of 1970 (Public Law 91-513) increased the level of authorizations for selected alcoholic and narcotic addict rehabilitation programs, authorized funds for programs of drug abuse education, and authorized special project grants for the treatment of drug addiction. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (Public Law 91-616) authorized additional programs of grants and contracts for the prevention and treatment of alcoholism and required that such projects be community-based wherever possible. The Drug Abuse Office and Treatment Act of 1972 (Public Law 92-255) required centers, where possible, to provide treatment and rehabilitation programs for addicts and others with drug dependency problems residing in the areas served by such centers.

BUDGET HISTORY

Construction Assistance

Under section 201 of the Community Mental Health Centers Act authorizations have been available since 1965 for the construction of community-based mental health centers. These authorizations have totaled \$600 million over a nine fiscal year period. Of this amount, only \$245.5 million, or 40.9 per centum, has actually been allocated to the program from appropriations. During the first five fiscal years of the construction program, 1965 to 1969, appropriations constituted 75 per cent of amounts authorized. During the last four fiscal years, 1970 to 1973, this percentage has dropped to 14.9 per centum. Twice in the last four years the Administration has asked for no money for the construction program.

Staffing Assistance

Section 224 of the Community Mental Health Centers Act authorizes funds for the purpose of meeting the initial costs of staffing community-based mental health center programs. Unlike the construction program, grants made for staffing purposes commit the Federal government to long-term continuing obligations (eight years under present law).

Other Assistance

Assistance is also authorized for CMHC's for alcohol and drug abuse programs (sections 253, 256 and 261); consultation services (section 264); and children's mental health services (section 271).

The budget experience under these programs is summarized in the following table.

The table includes for comparison the authorizations proposed under H.R. 4925.

TABLE 6.—COMMUNITY MENTAL HEALTH CENTERS, COMMUNITY MENTAL HEALTH CENTERS ACT

[In millions of dollars]

Fiscal year and grant program	Authoriza- tion	Budget request	Appropria- tion	Obligation	Outlays
1970:					
Construction, sec. 201	70.0	40.0	35.50	23.995	24.755
Staffing, sec. 224:					
Initial	32.0	17.46	17.5	20.709	16.078
Continuing	(1)	33.84	30.8	26.840	16.078
Total	32.0	51.3	48.3	47.549	32.156
Alcohol and drug abuse programs, secs. 253, 256, 261	15.0	12.0	10.0	3.057	4.683
Consultation services, sec. 264					
Children's mental health, sec. 271					
Total	117.0	103.13	93.80	74.601	61.594
1971:					
Construction, sec. 201	80.0	0	0	23.677	32.533
Staffing, sec. 224:					
Initial	45.0	0	18.8	18.819	30.0
Continuing	(1)	60.1	71.3	71.22	30.0
Total	45.0	60.1	90.1	90.039	60.0
Alcohol and drug abuse programs, sec. 253, 256, 261	63.0	22.4	22.4	29.4	6.8
Consultation services, sec. 264	5.0	0	0	0	0
Children's mental health, sec. 271	12.0	0	0	0	0
Total	205.0	82.5	112.5	143.116	99.333

See footnotes at end of table.

TABLE 6.—COMMUNITY MENTAL HEALTH CENTERS, COMMUNITY MENTAL HEALTH CENTERS ACT—Continued

[In millions of dollars]

Fiscal year and grant program	Authoriza- tion	Budget request	Appropri- ation	Obligation	Outlays
1972:					
Construction, sec. 201.....	90.0	0	15.0	.586	30.898
Staffing, sec. 224:					
Initial.....	50.0	14.2	44.2	46.318	47.691
Continuing.....	(1)	90.9	90.9	88.766	47.692
Total.....	50.0	105.1	135.1	135.084	95.386
Alcohol and drug abuse programs, secs. 253, 256, 261.....	102.0	94.993	89.490	77.695	18.547
Consultation services, sec. 264.....	5.0	0	0	0	0
Children's mental health, sec. 271.....	26.0	0	10.0	9.979	.998
Total.....	267.0	200.093	249.590	223.344	145.829
1973:					
Construction, sec. 201.....	100.000	0	20.000	0	20.157
Staffing, sec. 224:					
Initial.....	60.000	0	40.000	40.463	(3)
Continuing.....	(1)	125.100	125.100	124.637	(3)
Total.....	60.000	125.100	165.100	165.100	144.460
Alcohol and drug abuse programs, sec. 253, 256, 261.....	154.000	82.461	66.361	468.947	34.541
Consultation services, sec. 264.....	5.000	0	0	0	0
Children's mental health, sec. 271.....	30.000	8.600	20.000	20.000	18.528
Total.....	349.000	216.161	271.461	254.047	217.686
1974:					
Construction, sec. 201.....	20.0	0	14.250	⁵ (34.250)	(18.627)
Staffing, sec. 224:					
Initial.....	49.131	0	30.263	(30.263)	(3)
Continuing.....	(1)	125.25	125.25	(125.250)	(3)
Total.....	49.131	125.25	155.513	(155.513)	(122.411)
Alcohol and drug abuse programs, secs. 253, 256, 261.....	98.474	66.613	81.761	⁶ (95.927)	(47.964)
Consultation services, sec. 264.....	0	0	0	0	0
Children's mental health, sec. 271.....	20.0	8.448	19.0	(19.0)	(10.474)
Total.....	197.605	200.311	270.524	304.690	199.476
Total, existing law.....	1,135.605	802.195	997.875	999.798	723.918
1975:					
Construction, sec. 201.....	20.0	0	0		
Staffing, sec. 224:					
Initial.....	49.131	0	0		
Continuing.....	(1)	172.1	172.1		
Total.....	49.131	172.1	172.1		
Alcohol and drug abuse programs, secs. 253, 256, 261.....	98.474				
Consultation services, sec. 264.....	0	0	0		
Children's mental health, sec. 271.....	20.0	26.8	26.8		
Total.....	⁷ 197.605	198.9	⁷ 198.9		
1976:					
Planning, sec. 202.....	3.75	0			
Operation, sec. 203.....					
Initial.....	50.0				
Continuing.....	(1)	159.9			
Consultation and education, sec. 204.....	10.0	0			
Conversion, sec. 205.....	20.0	0			
Financial distress, sec. 211.....	15.0	0			
Facilities assistance, sec. 228.....	5.0	0			
Total.....	⁸ 103.75	159.9			

See footnotes at end of table.

TABLE 6.—COMMUNITY MENTAL HEALTH CENTERS, COMMUNITY MENTAL HEALTH CENTERS ACT—Continued

[In millions of dollars]

Fiscal year and grant program	Authoriza- tion	Budget request	Appropria- tion	Obligation	Outlays
1977:					
Planning, sec. 202.....	3.75				
Operation, sec. 203.....					
Initial.....	55.0				
Continuing.....	(¹)				
Consultation and education, sec. 204.....	15.0				
Conversion, sec. 205.....	20.0				
Financial distress, sec. 211.....	15.0				
Facilities assistance, sec. 228.....	5.0				
Total.....	113.75				
Total H.R. 4925.....	217.5				

¹ Needed sums.² Obligations exceed appropriations due to carry over authority.³ Unavailable.⁴ Includes \$10,742,000 appropriated but not obligated in 1972.⁵ Includes \$20,000,000 appropriated but not obligated in 1973.⁶ Includes \$17,062,000 appropriated but not obligated in 1973.⁷ H.R. 4925 provides for a simple extension of existing authority for fiscal year 1975. The CMHC program is presently being funded at the indicated level under continuing resolution.⁸ Budget request does not correspond to the authorizations in H.R. 4925 because the legislative authority is rewritten in H.R. 4925 and the request is based on the old authority.

PROGRAM BACKGROUND

Requirements of the States

Under the provisions of the Community Mental Health Centers Act, the States are required to prepare and submit to the Secretary of Health, Education, and Welfare for his approval, a State plan in order to take advantage of the programs authorized under the Act. This plan must conform to a number of requirements, including:

(1) specifying a single State agency for administering the plan and meeting other administrative requirements;

(2) containing a program for construction of CMHC's which (a) is based on a Statewide inventory of need, (b) conforms with certain regulations of the Secretary, and (c) meets the requirements for the provision of services to persons who are unable to pay for them;

(3) establishing, on the basis of relative need, priorities for construction projects; and

(4) specifying standards for the maintenance and operation of centers and providing for the enforcement of such standards.

Regulations issued by HEW prescribe the kinds of services that must be included in a State plan to provide adequate mental health services for persons residing in the State. These include: (1) inpatient services, (2) outpatient services, (3) partial hospitalization services, (4) emergency services, (5) consultation and education services, (6) diagnostic services, (7) rehabilitative services, (8) pre-care and after-care services, (9) training, and (10) research and evaluation. The first five are considered "essential services" which all CMHC's must provide. The second five are optional "supplemental services".

The State plan must define catchment areas for centers which will serve a population of not less than 75,000 and not more than 200,000

unless otherwise specified by the Secretary. Centers must also be located near and readily accessible to the community and population which they will serve. Each plan must contain policies and criteria that will be used to evaluate the adequacy of financial support for the maintenance and operation of programs, including such factors as the source of funds and the per capita and family income range of the population to be served. The plan must also be consistent with the mental health planning activities of the State and, to the extent possible, consistent with other health, welfare and physical development plans and activities occurring in such State.

Requirement of Grantees

Only public and private nonprofit agencies and organizations may apply for construction and/or staffing grant assistance under the Community Mental Health Centers Act. Eligible nongovernmental applicants include existing agencies and organizations or special purpose corporations and associations established specifically for the purpose of applying for staffing or construction grants. Applicants are not required to provide services with their own personnel, but may affiliate with other agencies and organizations to provide facilities or to operate all or part of a center program.

As a minimum, applicants must be prepared to provide at least the five "essential" mental health services. Although these services are mandatory, the regulations do not require any specific allocation of staff or financial resources to any particular service. Services must be available to all residents of a catchment area regardless of age, sex, race, creed, color, national origin, diagnostic category, voluntary or involuntary status, or ability to pay.

The Catchment Area Concept

The Community Mental Health Centers Policy and Standards Manual notes that "the catchment area concept is the cornerstone" of the programs funded under the Act. A CMHC is responsible for making available the necessary services required to meet the mental health needs of the population residing in a defined geographical area. Any given geographical area can be part of only one catchment area. A center is permitted to serve persons who reside outside its catchment area, but only where such service does not adversely affect the center's ability to serve the population for which it is primarily responsible. As noted above, the responsibility for the determination of catchment area boundaries rests with the State and must be designated in the State plan.

Number of Community Mental Health Centers Supported

As of December 1, 1974, 591 centers had received Federal financial assistance under the Community Mental Health Centers Act. Of the funded centers, approximately 443 were operational. These 591 centers, when fully operational, will make services available in catchment areas containing 41 percent of the total United States population (86 million people). Over half the funded centers are in designated poverty areas and over half have received both construction and staffing grant assistance. All 50 States, Guam, Puerto Rico and the District of Columbia now have funded centers in a variety of facility settings and rural-urban locations.

TABLE 7.—CENTERS FUNDED UNDER THE CMHC ACT

Category	Number	Percent
Total centers funded.....	591	100.0
Type of grants received:		
Construction only.....	106	17.9
Staffing only.....	178	30.1
Construction and staffing.....	307	51.9
Location of center:		
Poverty area.....	322	54.5
Nonpoverty area.....	269	45.5

TABLE 8.—CENTERS FUNDED UNDER CMHC ACT; URBAN-RURAL POPULATIONS SERVED AND TYPE OF SETTING, 1972

Urban-rural population:		
Cities over 500,000 population.....	81	15.0
Cities of 25,000 to 500,000.....	264	48.8
Cities less than 25,000.....	195	36.2
Type of setting:		
General hospital.....	92	17.0
Mental health clinics.....	8	1.4
Mental health center and special purpose corporation.....	128	23.8
Mental hospitals.....	16	2.9
Local government units and charitable organizations.....	296	54.9

Grants for specialized services for children were awarded to 60 facilities. Specialized grants for services for alcoholics were made to 91 centers. Sixty-nine centers received grants for specialized services for drug addicts.

There are 1,492 catchment areas in the United States of which HEW estimates that 502 are eligible as poverty areas. There were 56 centers (just over 10% of the 493) serving areas whose populations do not conform to the conditions prescribed for catchment areas. Of these, 25 were located in "undersized" (under 75,000) areas and 31 were serving populations in excess of the 200,000 population limit required by regulations.

Sources of Center Funding

Over \$3 out of every \$4 received by CMHC's are from government sources. Receipts from services provided by centers accounts for less than a quarter of the total monies received. Federal government funds are the largest source of center receipts (35.2%) with states providing a significant amount (30.7%).

TABLE 9.—PERCENT DISTRIBUTION OF SOURCE OF FUNDS FOR COMMUNITY MENTAL HEALTH CENTERS, 1972

	Poverty areas	Nonpoverty areas	All center
All funds	100.0	100.0	100.0
Government funds.....	79.2	72.9	76.1
Federal funds.....	41.8	28.2	35.2
Staffing grants.....	(36.4)	(24.6)	(30.7)
Construction grants.....	(1.3)	(1.3)	(1.3)
Research and training.....	(1.7)	(1.1)	(1.4)
Other Federal.....	(2.4)	(1.2)	(1.8)
State funds.....	29.3	32.2	30.7
Local and other government funds.....	8.1	12.5	10.2
Receipts from direct services.....	17.7	24.7	21.1
Patient fees.....	3.4	4.6	4.0
Insurance (commercial).....	4.4	11.4	7.7
Medicare.....	1.1	2.3	1.7
Medicaid.....	6.7	4.6	5.7
Schools and other.....	2.0	1.8	1.9
Philanthropy, other fund raising and indirect services.....	3.1	2.4	2.5

Expenditures by Community Mental Health Centers

Nearly two-thirds of the expenditure by CMHC's are for staff salaries. Operating outlays account for 27 per centum of center expenditures while the remaining 8 per centum is for capital and other expenditures.

TABLE 10.—DISTRIBUTION OF EXPENDITURES BY COMMUNITY MENTAL HEALTH CENTERS, 1972

	Amount (in thousands)	Percent
Type of expenditure:		
Salaries of personnel.....	\$221,472	65.2
Operating expenditures.....	92,501	27.2
Capital expenditures.....	10,397	3.1
Expenditures for contracted services.....	15,156	4.5
Total.....	339,525	100.0

Manpower in Community Mental Health Centers

Shown below is the distribution of the manpower employed by CMHC's and its employment status. Nursing personnel account for the largest number of full-time center employees, while psychiatric physicians represent the largest group of part-time workers.

TABLE 11.—DISTRIBUTION OF STAFF IN COMMUNITY HEALTH CENTERS

[In percent]

Discipline	All staff	Full time	Part time
Psychiatrists.....	8.2	4.3	21.3
Other M.D.'s.....	1.7	.4	5.1
Psychologists.....	5.8	5.5	8.0
Social workers.....	10.3	11.3	8.8
Registered nurses.....	11.1	12.2	11.3
Vocational rehabilitation workers.....	1.3	1.4	1.0
Occupational therapy workers.....	2.0	1.8	2.1
Recreational therapy workers.....	2.9	2.4	2.4
Other professionals.....	12.0	8.6	7.9
LPN's nurses' aides, etc.....	19.1	22.0	18.1
Other nonprofessional mental health workers.....	6.6	5.3	2.9
Clerical, fiscal maintenance, etc.....	19.0	24.8	11.1
Total, all personnel.....	100.0	100.0	100.0

Characteristics of clientele served

During 1972, centers funded under the Community Mental Health Centers Act provided services to 846,336 persons. Relative to the U.S. population as a whole, centers serve a disproportionate number of persons from lower income groups. Over 42 percent of the clients served were from families with incomes of less than \$2,500.

TABLE 12.—PERSONS SERVED IN MENTAL HEALTH CENTERS, BY FAMILY INCOME

[In percent]

Family income	Served by centers	U.S. population 1969
All incomes.....	100.0	100.0
Under \$2,500 ¹	42.2	14.8
\$2,500 to \$4,999.....	20.4	14.9
\$5,000 to \$7,499.....	17.8	30.2
\$7,500 to \$9,999.....	10.3	
\$10,000 to \$14,999.....	6.3	22.1
\$15,000 and over.....	3.0	17.9

¹ Includes persons with no income and on welfare.

Data also indicate that centers serve substantially the same distribution of clientele by family income regardless of whether the centers are located in poverty areas or non-poverty areas.

More than 40 per centum of the persons served in CMHC's were under the age of 25. Persons 15 or under accounted for 16.7 per centum of the entire patient load. Only 3.9 per centum of the clientele served were 65 or older.

Clientele served by type of service and diagnosis

Nearly 3 out of every 4 persons treated in CMHC's utilize the outpatient services provided by the centers. Only 23 per centum of the patients required inpatient care, while 4 per centum needed partial hospitalization services. Nine per centum of the persons helped were treated for alcohol or drug disorders.

TABLE 13.—CLIENTELE SERVED BY TYPE OF SERVICE AND DIAGNOSIS

	Percent distribu- tion
Total, all services.....	100.0
Outpatient.....	75.9
Inpatient.....	15.7
Partial hospitalization.....	8.4
Total, all diagnosis.....	100.0
Alcohol disorders.....	7.2
Drug disorders.....	1.8
Brain syndromes.....	3.4
Depressive disorders.....	4.8
Schizophrenic reaction.....	14.2
Other psychotic disorders.....	1.8
Psychoneurotic disorders.....	17.9
Other personality disorders.....	11.9
Other mental disorders.....	20.1
Without mental disorder.....	2.6
Undiagnosed.....	14.3

Services for children and the aged

Community Mental Health Centers attempt to serve all in need within their catchment area responsibility. They have, however, lacked the resources, outreach programs and incentives to deliver services to two groups with great needs, children and the aged. These "populations-at-risk" have special problems and only specially targeted programs and specially trained professionals are equipped to handle these patients and potential patients.

A special categorical grant program was established in 1970 for children's programs. This has led to an expansion of services to this age group. Staffing grants for specialized services to children have been made under Part F of the CMHC Act to 91 locations in 38 States. Forty-nine of these grants have been in poverty areas.

For persons at the opposite end of the spectrum, the aged, no comparable special grant program has existed. The number of elderly under care in community mental health centers and other outpatient psychiatric services as a proportion of all patient care episodes in these facilities in 1971 is quite small. The elderly receive only seven percent of CMHC inpatient services, three percent of CMHC outpatient services and two percent of other outpatient psychiatric services.

Data from a 1969 National Institute of Mental Health survey of patients discontinued from the inpatient services of State and County mental hospitals show that for the 37,000 discontinuations of patients 65 years of age and over, the proportion referred to other types of psychiatric services was relatively small. Fifteen percent were referred to outpatient psychiatric services, four percent to community mental health centers, four percent to transitional mental health facilities, and four percent to other mental hospitals. This compares with almost two-fifths referred to nursing homes or homes for the aged. This indicates that community-based psychiatric facilities (community mental health centers, outpatient psychiatric services

and transitional mental health facilities) are playing a relatively minor role in the care of the aged mentally ill as their numbers decline in psychiatric hospitals, whereas nursing homes and homes for the aged assume a substantial part of the burden of caring for this population.

CMHC's and State mental hospitals

The Committee sees compelling evidence of the progress of community mental health care in reducing inappropriate admissions to state mental hospitals.

Since 1958, the resident population of State mental hospitals has been sharply reduced, from 570,000 to 248,564 in 1973. The pattern of decrease in inpatients for the period 1970 through 1973 is shown in the table below.

The reasons for this decline in state mental hospital populations relate to many factors. These factors include the increased availability and utilization of outpatient and aftercare facilities which make possible a reduction in the length of stay of admissions; initiation of community mental health centers and affiliation of CMHC's with State mental hospitals; more effective screening procedures to prevent inappropriate admissions; and deliberate administrative efforts to reduce the resident population. These factors are, of course, highly interrelated and affect the rates of admission, readmission, and duration of stay.

TABLE 14.—NUMBER AND PERCENT CHANGE IN INPATIENTS AT END OF YEAR, INPATIENT SERVICES OF STATE AND COUNTY MENTAL HOSPITALS: UNITED STATES 1970-73

State	Number of inpatients end of year				Percent change			
	1970	1971	1972	1973	1970-71	1971-72	1972-73	1970-73
United States, total.....	337, 619	308, 983	274, 837	248, 562	-8.5	-11.1	-9.6	-26.4

The impact of the centers on the admission rates to state mental hospitals can be assessed by comparing the rate of admission of persons living in catchment areas served by CMHC's and of the United States population as a whole. These data show that in the initial years of operation, centers generate an *increase* in admissions to State mental hospitals—a result of casefinding activities and the fact that the center is not yet operating at full strength. However, centers in operation for several years show a dramatic effect on the rate of admissions to state mental hospitals. The possibility of a person being admitted to a state mental hospital from catchment areas where a center has been operating three or more years is reduced by one-third as compared to the U.S. rate of admission.

TABLE 15.—STATISTICS BEARING ON THE CMHC PROGRAM OBJECTIVE TO DECREASE THE INAPPROPRIATE UTILIZATION OF STATE HOSPITALS

Years center has been in operation	Catchment area residents in State mental hospitals, 1971			Admissions of CA residents to State mental hospitals, 1971		
	Number	Rate per 1,000 CA residents	Ratio of CA rate to U.S. rate (=1.51)	Number	Rate per 1,000 CA residents	Ratio of CA rate to U.S. rate (=2.063)
All centers ¹	14,959	1.11	0.74	23,210	1.73	0.85
Under 1½ years.....	2,322	1.26	.83	3,872	2.09	1.03
1½ to 3 years.....	4,119	1.14	.75	6,619	1.84	.91
3+ years.....	8,518	1.07	.71	12,719	1.59	.78

¹ Data are based on reports from 94 of the 294 operating centers in 1971.

Community residential services

Over one million citizens today are living in State mental hospitals and nursing homes. Studies have indicated that for one-fourth to one-third of this population, institutional care is inappropriate. Living with families or in other community settings with supportive services would facilitate the capability of these individuals to live more independent, functional lives and avoid unnecessary institutionalization. In addition, increasing numbers of mentally impaired adults who require institutional care or who are the victims of "administrative discharge" from State hospitals are residing in community settings with inadequate services. Many are indigent; many are without families or other resources to assist them.

As noted above, in the past fifteen years State mental hospital population decreased by over 300,000, with most of these patients returning to community settings. State mental hospital admissions have risen and length of stay has decreased. These trends are increasing throughout the States and the social and medical problems are compounded in proportion to the numbers involved when adequate community support is not available.

The scarcity of comprehensive community-based resources inhibits the potential of family and community to function as therapeutic agents and limits the alternatives to institutionalization. Augmenting and improving community resources will facilitate the reduction of inappropriate institutional care, enhance the capability of mentally impaired people to maintain themselves in the community, and produce benefits to consumers, providers, and taxpayers alike.

Cost of care in CMHC's

CMHC's make maximum use of outpatient and partial hospitalization services, keeping inpatient admission low. The length of stay of persons admitted for inpatient care is also kept to a minimum (18 days average length of stay, compared to 41 days in state mental hospitals). This not only is better for the patient, but also means

that CMHC's are able to provide fully comprehensive care at a reasonable cost and keep their patients in the community—often working full-time—and return them quickly to fully productive lives. Since the cost of mental illness in terms of lost productivity alone is in the billions of dollars each year, the potential savings if all citizens had access to community mental health care is enormous.

TABLE 16.—UTILIZATION DATA, FEDERALLY FUNDED COMMUNITY MENTAL HEALTH CENTERS, 1971-72

	Total	Average per CMHC
Caseload at beginning of reporting year.....	334, 630	1, 030
Additions during reporting year.....	511, 706	1, 574
Persons under care during year.....	846, 336	2, 604
Persons discontinuing service.....	421, 938	1, 298
Persons on roll at end of year.....	424, 398	1, 306
Estimated annual number of outpatient episodes.....	701, 527	2, 159
Individual outpatient sessions.....	2, 933, 418	9, 026
Family outpatient sessions.....	412, 946	1, 271
Group sessions.....	556, 352	1, 712
Estimated number of annual inpatient episodes.....	144, 601	445
Number of inpatient beds.....	10, 441	32
Percent occupancy.....	69	
Average days of care per occupancy.....	17.7	

CONCLUSIONS

From its study of the CMHC program to date, described above, the Committee has drawn several conclusions. First, it is clear that the CMHC Act and the program operated under it has generally been a success in creating community alternatives to state inpatient facilities for mental health care. Approximately one-third of the nation is now served by CMHC's assisted with funds provided under the Act. The success of the program has led the Committee to conclude that the original intent of the Act—to provide funds with which to start centers throughout the nation—must be reaffirmed. In addition, the Committee wishes to affirm its strong belief that the existing mental health centers put in place under this Act must be maintained, strengthened and expanded at this time, to ensure that until some form of national health insurance covers the costs of care provided by these centers high quality and comprehensive mental health services continue to be offered in the communities.

The preponderance of evidence received by the Committee attests to the fact that the CMHC program has been highly effective in improving the delivery of mental health care within the community. The Administration agrees with the Congressional finding that the program is successful. The administration, however, concluded that the CMHC program has demonstrated its value and no longer requires Federal support; its rationale is that Federal third party payment programs (Medicare and Medicaid) together with States and communities and other third party payment systems, will provide the funds needed to support existing centers—and initiate the new centers needed to reach every community.

The Committee is deeply concerned that no evidence to support this position has been provided.

First, on the issue of alternative funding for centers, the Administration cites Medicare and Medicaid as important funding sources for centers. Yet in 1972, the Committee notes, these two massive financ-

ing programs which spent over \$17 billion in total provided only \$25 million in payments to the existing CMHCs, representing only 7.4% of the total funding for their operation.

Reimbursements from Medicare are severely curtailed both by the legislation—which emphasizes hospital-based services—and by the fiscal intermediaries which administer the program. Under the legislation, free-standing CMHC's have found it almost impossible to qualify as providers of care for inpatient services, as they do not meet the definitions in the law which are more suited to large psychiatric hospitals. Furthermore, many of the other services provided through the centers by personnel who are not physicians cannot be reimbursed through Medicare.

Limitations on repayments through Medicaid are even more restrictive, and are complicated by the fact that each State administers its own Medicaid program. Medicaid eligibility standards vary from State to State, and often exclude many low income persons, particularly the working poor. Mental health services which states are required to cover under their Medicaid programs include only outpatient hospital services of a psychiatric hospital (most CMHC's cannot qualify under this definition), screening services for children under 21, and physicians' services. Medicaid does allow States, on an optional basis, to cover clinic services. This is the mechanism under which Medicaid payments to CMHC's can sometimes be made. However, only 36 States elect to cover clinic services in their Medicaid plans, and only 9 of these specifically include CMHC's in their clinic services definition. In many of the other States the definition of a clinic effectively excludes mental health centers.

Because of the varying State programs, reimbursements through Medicaid vary drastically from center to center. In some States, CHMC's receive reasonable reimbursements through Medicaid for services to those who are eligible. In other States, they receive no reimbursement through Medicaid.

The Committee has determined that private insurance, another funding source which the Administration has cited as a source to replace federal funds, provided only 7.7 percent of all center funds in 1972. The Committee notes that private insurance policies generally discriminate against outpatient and other forms of less intensive (and less expensive) care in favor of inpatient stays.

Revenue sharing also has been suggested as a source of funds. General revenue sharing is being used for many purposes in the states and localities, but support of CMHC's is not primary among them. A survey conducted by the National Council of Community Mental Health Centers in 1973 found that only 22 centers have received financial aid as a result of revenue sharing payments, and in most instances the amount of the assistance was quite low, less than \$5,000. Moreover, States and localities have already invested heavily in CMHC's. In 1972, they contributed about \$425 million, almost 41% of total CMHC receipts, and they are finding it very difficult to substantially raise their support level.

On the basis of its analysis of the CMHC funding situation, the Committee must conclude that sufficient funding sources other than Federal grants are not now available to continue the services of the 500 existing CMHC's, let alone to work toward our goal of 1500 CMHC's

needed to bring mental health services within the reach of every community.

The costs of mental illness now run in the billions of dollars each year. If the Federal government withdraws its support for community programs, the alternative for most of the people now served by the centers would be the State mental hospital system. For those with private insurance coverage, other forms of care would be available—but since these policies generally emphasize more expensive inpatient care over outpatient and partial hospitalization, this too will cost society more.

It is the Committee's position that services for the mentally ill and emotionally disturbed must be provided and that CMHC's have proved an effective and economical means to provide fully comprehensive care within the patient's community. Thus the Committee believes that reducing Federal expenditures in this area now is "penny wise-pound foolish," as the country must obtain these resources from one source or another.

The President is rightly concerned over the relationship between Federal spending and Federal revenues at this time. However, severely cutting back essential health services is not sound economics. It is even more inappropriate at this time to reduce our commitment to mental health care. Recent studies, particularly by Dr. M. Harvey Brenner, Johns Hopkins University, show that the nation's economic health is a sure indication of its mental health. Economic fluctuations are the single most important source of changes in mental-hospital admission rates.

The conclusions of the Brenner study are already being proved in the current recession. While hard, nationwide data are hard to come by, individual community mental health centers are reporting dramatic increases in demands for services. For example, the Range Mental Health Center in Virginia, Minnesota has experienced a 300 percent increase in demand over a recent 3-month period. Many centers in other parts of the country are finding similar increases. The increased patient load at the Range Center appears to the Range staff to reflect the impact of the economic recession.

The President, in justifying his veto of HR 14212, expressed concern over two issues: economy and equity. The Committee believes that, to the contrary, we must continue to strengthen mental health care in order to help those Americans who are suffering most from the current recession, and that specifically, we must continue and strengthen the current CMHC program, pending its replacement with a more equitable and nationwide health insurance system.

The fact of the matter is that there is no viable alternative at the present time to continued Federal grant support for community mental health centers.

The problem is partly a question of timing. Our Nation is moving toward expanded insurance coverage for mental health services that will ultimately allow CMHC's to become self-sufficient. The Committee believes it would be shortsighted and irresponsible to terminate Federal support for CMHCs and thereby both jeopardize the continued operation of existing centers and eliminate center expansion, particularly at a time when a program of national health insurance is being actively considered for enactment in the Congress, and when broad-

ened mental health coverage provisions are being added to many private insurance programs.

The Committee therefore confirms the original intent of the CMHC Act of 1963: That the Federal role is one of providing construction and operational funds to new centers to initiate a program of mental health services on a community basis throughout the nation. The operational funding is to be for a limited period of time on a declining basis with the ultimate goal that the centers to the maximum extent feasible become completely independent of Federal support.

Presently, there are almost 500 operational centers, yet there are 1,500 catchment areas in the United States. Thus, only one-third of the community mental health center system has been put in place to date.

Pending action to provide funding for these services through an equitable national health insurance program, the Committee believes it is imperative to meet the following needs:

The need to continue the steady increases in the number of operational centers until the national goal of providing CMHC services in every community is attained;

The need to establish national standards for centers, based upon previous experience, and to require both existing and new centers to provide more comprehensive services, improved management and financial administration and assurances of quality consistent with these standards;

The need for changes in the operation of the program to encourage self-sufficiency, and to facilitate the shifting of funding for these vital programs from the current categorical grant program to both public and private third party payment mechanisms;

The need for more comprehensive planning and evaluation for services at the Federal and catchment area levels and better integration of CMHC services and State mental hospitals into a complete system of mental health care;

The need for a separate program within the centers for vital preventive and other consultation and education services.

Unless we take these steps to maintain, and indeed expand and improve, the system for delivering community mental health services, enactment of national health insurance will not solve the problem of inadequate, in equitably distributed mental health services; it could also be highly inflationary if cost and quality controls are not in place.

As a result of the administration's opposition to this and other health programs, the need for enactment of this legislation is now urgent. Some thirty-six centers will receive their last Federal staffing grant before June 30, 1975 and many of these will be forced to reduce or severely curtail services. A recent survey by the National Council of Community Mental Health Centers showed that at least twelve of these centers would need further Federal aid if they are to continue their current services (66.6% of those responding to the survey). Services to be cut back by those centers unable to replace lost Federal funds were generally consultation and education, outpatient, partial hospitalization, emergency services and various specialized programs, such as programs for children or elderly persons.

Thus, the need for this legislation is clear. Prior to the enactment in the reasonably near future of a national health insurance bill to cover the costs of most direct health care services, the Committee believes we must not permit the existing system of health care delivery to deteriorate. If we do, the Committee is concerned that we will only find that it must be rebuilt if NHI is to be effective and not inflationary. The provisions of Title III of H.R. 4925 are designed to maintain and improve the system of mental health care prior to enactment of NHI. They will also ensure a slow but steady expansion in the level of services available, at a time when substantial increases in demand for services are already evident and, judging by the state of the economy, can be expected to continue.

Unlike Medicaid, the CMHC program does not discriminate between individuals in different States: all States have at least one CMHC program. Unlike Medicare, it does not discriminate against those with mental disabilities by restricting coverage for such services. The program has been facing a highly uncertain future since the Administration first proposed its termination in 1972. Yet demands from communities for new and expanded community mental health centers (as indicated by the number of applications for Federal support) remains strong. The Federal government must continue toward its long-stated goal of providing seed money to establish centers in all communities. This is equitable and economical. More importantly, however, it will bring quality mental health services within the reach of thousands of Americans now effectively denied such care.

It is also clear that the program has fiscal constraints and encountered operating difficulties that can be partially solved by modifications in the legislation. For example:

Centers frequently administer a confusing collection of categorical staffing grants rather than one operating grant to cover all their services.

Centers vary in the range of services they offer, and the law is unclear on Congress' intent in this regard.

Many centers do not make sufficient efforts to collect all possible third party and private payments for services.

Centers vary in the extent to which they work effectively to screen admissions to state mental hospitals and facilitate the transition of former psychiatric hospital inpatients back into the community.

Centers have failed to adequately evaluate their operations and programs.

The proposed legislation attempts to provide centers the resources and incentives to effect improvements in these areas. Similarly, it is recognized that CMHC's have generally not been a major source of mental health care to our middle and upper income people, because they lack adequate resources to serve all people and have given priority to the medically indigent. CMHC's have also not proved successful in collecting third party reimbursement for their services. It is hoped by the Committee that in continuing and expanding the program the Department of HEW will continue to assure that CMHC's are available as a resource for poor people but will also make resources available so that they can serve all people. Further, it is hoped that HEW, working with the centers, can improve third party reimbursement in anticipation of the coming of national health insurance.

PROPOSED LEGISLATION

Title III of the proposed legislation constitutes a complete revision of the Community Mental Health Centers Act. The general nature of and the reasons for this revision are discussed in the following section. The specific nature of the revision is described in detail in the section-by-section analysis of H.R. 4925, which follows.

In adopting the provisions of title III, the Committee reaffirms its original policy of providing seed money for starting new centers on a time limited, declining basis and its original intent that the services of such centers should eventually be made available throughout the nation.

The Committee has also chosen to extensively revise the legislative authority under which this support is provided using the accumulated experience of the last eleven years. These revisions are described below.

Definition of a Community Mental Health Center

The new legislative authority will for the first time prescribe a definition of a CMHC and of the comprehensive mental health services which such a center must provide. The definition contains requirements for the organization and operation of such centers, provision of services, coordination of services with other entities and development of an integrated system of care, staffing, availability of services, responsiveness to the community served, governing bodies, quality assurance and related matters. This definition of a CMHC will serve as the focal point of the CMHC program in that it provides a clear description of what a center is and a standard by which individual centers and the program as a whole may be judged.

The bill requires all existing centers as well as new centers to meet the definition and the requirements, within two years, as a condition of obtaining or continuing grant support. The services required to be provided in a CMHC incorporate those now required under regulations as "essential services" and adds to them specialized services to children, the elderly, alcoholics and drug dependent persons. These services include those which have been the subject of special legislative consideration in the last five years, and, with the exception of services for the elderly, have been authorized through separate provisions of the CMHC Act (sections 253, 256, 261 and 271). The new definition now requires each CMHC to provide all stipulated services and repeals the existing separate authorities.

Included in the list of required services are two service programs which, with the approval of the Secretary, need not be provided if there is insufficient need for them or if the need is already being met in the community: drug abuse and alcoholism programs. This option regarding these vital programs is provided only to assure that duplication of such vital but expensive services will be avoided.

The bill also requires each CMHC to coordinate its services with those provided by health and social service agencies in the community in order to integrate mental health care with any other health and social services an individual may require. It is the Committee's intent that CMHC's continue to work toward a system of integrated health care which assures continuity and high quality care, and to make services readily accessible to all residents of the community in a manner that overcomes all barriers to the receipt of services.

In developing the CMHC legislation, Congress intended that all centers provide fully comprehensive programs for all residents in their catchment area. However, in practice many centers have been unable to develop the comprehensive and highly specialized programs needed by children and elderly persons and coordination between state mental hospitals and CMHC programs is often inadequate. While recognizing the resource constraints which have hampered provision of comprehensive specialized programs for children and the elderly, the Committee nonetheless believes that all CMHC's must offer these specialized services to be considered to have a comprehensive program.

The Committee is disturbed by the failure in many instances of CMHC's and State mental hospitals to better integrate their systems of care. A study by the General Accounting Office describes, for instance, competition for patients, duplication of services and lack of follow-up care. Since a major objective of the CMHC legislation is to discourage the inappropriate placement of persons in inpatient facilities, pre-institutional screening of patients is a basic and essential element of any CMHC program. The Committee intends, through preinstitutional screening and the post-institutional referral requirements, to emphasize the role of the CMHC as an alternative to hospitalization, and to make it clear to the States that CMHC's are to provide after-care when needed. The Committee further intends to eliminate those situations where State mental hospital patients are discharged to their homes or to institutions in the community such as intermediate care facilities or personal care homes with no referral or follow-up arrangements made for them.

Programs of Assistance for CMHC's

H.R. 4925 consolidates and replaces the numerous current categories of aid to centers with six new grant programs: planning, operational support, conversion, consultation and education, financial distress and facility assistance.

Planning and development grants

H.R. 4925 authorizes planning and development grants for CMHC programs. These one-year grants would enable communities to develop plans for setting up a comprehensive CMHC, and, in drawing up such plans, the Committee expects applicants to give special attention to:

Location of each of the service units of the program with a view to accessibility (in terms of both transportation in the area and visibility of the unit itself);

The need for satellite elements which, to the maximum extent feasible, should result in the center's services being within reasonable traveling time from all residents of the area;

The hours during which outpatient and other nonemergency services should be available, including weekends and during non-working hours.

Initial operating grants

The bill replaces the current staffing grant program with a grant program to provide funds for a portion of all the operating costs (other than costs related to consultation and education) and a special consultation and education grant program. To receive support under the operating grant program a center must provide (or have an

approved plan for providing) the full range of services listed in the bill, including consultation and education services; and to receive a C & E grant the center must be providing all other comprehensive services. The C & E and operational grants are thus complementary. Operating grants would be available for eight years; C & E grants would have no time limit, reflecting the Committee's belief that consultation and education services are a continuing responsibility of the Federal Government.

Operating grants would be based on the lesser of two amounts: (a) the difference between the amount needed to run a comprehensive program and the amount the CMHC can reasonably be expected to collect from other sources or (b) a set percentage of operating costs similar to the current program. This formula is designed to facilitate an easy adjustment to expanded public or private third party payments. It replaces the formula for staffing grants in the current law, which provides a set percentage of staffing costs only.

The formula for operating grants will ensure that any center which is able to operate without continued Federal aid will do so, not after a set period of time as under the current law, but as soon as this becomes a practical proposition. Thus, although operating grants are available for up to eight years, centers able to generate sufficient funds from other sources will drop out of the Federal operating grant program before the expiration of the eight year period. In addition, centers unable to find alternative funding will be ensured of a full eight years of operational support and a three-year financial distress grant if needed. A similar formula is proposed for financial distress grants, and many centers will be able to drop out of the operation and financial distress grant programs under these formulae as soon as public and private insurance coverage increases ensuring a smooth transition to third party payment mechanisms.

(a) *Operating and Conversion Grants for Existing Centers.*—The requirements for fully comprehensive programs and for improvements in the operation and organization of community mental health centers should, the Committee firmly believes, apply to all programs—those funded prior to enactment of this legislation as well as those to be funded in the future. In meeting the new requirements for comprehensive services the bill permits new grants to be made to the existing centers for the purpose of adding these new services.

To merge existing centers into the revised program, the bill encourages centers funded under the old law (through the staffing grant program) to apply for funding under the new operating grant program. To determine the percentage of support, centers would be deemed to have been in operation a number of years equal to the number of years the center has been awarded staffing grants under the old law.

Existing centers applying for operating grants under the new program would be required to meet certain standards for operating and governing the CMHC (Sec. 201 (b) (2), (c) and (d)), and would also be required, within two years, to meet all of the services requirements.

In addition, to assist the existing centers in meeting the new requirements for comprehensive services, the bill authorizes grants for up to two years for meeting the operating deficit resulting from the provision of the new services required under this legislation. These conversion grants would be available to all existing centers to assist

them in meeting the high initial costs of instituting new services. At the end of the two year period, funding for these services would be provided through the operating grant program in the same manner (and at the same rate) as for the center's other services.

Finally, the bill authorizes continuation of grants awarded under the old law for existing centers which are unable to meet the requirements of the new legislation for operating grant applicants. These continuation grants would be made under the same conditions and for the same length of time as authorized under the old law, with the additional requirement that no more than two continuation grants may be awarded unless the center meets the definition of a CMHC under section 201 of this legislation (including the requirements for comprehensive services). Continuation grants are further limited to no more than the center's operating deficit in any year. A grantee under this provision may not receive any grant for initial operation under the new section 203, and any grantee which receives such an initial operation grant may not receive a "continuation" grant under this provision.

These provisions (together with the requirement that CMHC's applying for consultation and education grants meet the definition of a CMHC in this legislation) are designed to merge the existing programs into the new program envisaged under this legislation. The Committee does not believe it is appropriate for the Federal government to fund two different types of CMHC's: Those funded under the old legislation and generally providing only the five essential services now required and those funded under these amendments which would not only provide more comprehensive services, but would also be required to meet new stricter standards of operation and fiscal accountability designed, in part, to ensure that they are able to make maximum collections from all available third party financing programs, including federal third party payments.

Thus, under H.R. 4925 all CMHC's will be required to meet the standards set in this legislation, including the comprehensive service requirements, within two years of enactment or within two years of initial operation of a new CMHC. Existing centers failing to meet these standards within the prescribed period will be ineligible for any further Federal assistance under this Act, including continuation funding of staffing grants previously awarded.

(b) *Initial operation grants—phase-in of comprehensive services.*—Recognizing that comprehensive service requirements will frequently require some lead time to fully develop, the bill provides that both new and existing centers may receive operating grants for two years even if they do not provide all of the comprehensive services.

Consultation and education grants

H.R. 4925 authorizes consultation and education grants to CMHC's in their fifth year of operation (or if the Secretary determines that as a result of the declining percentage of a CMHC's costs of operation or staffing available to it under its initial grant, it is unable to offer adequate consultation and education services, he may make such an award in the third or fourth year of operation). Any center receiving a consultation and education grant shall not include the cost of providing consultation and education services in the total cost of opera-

tions used as a basis for calculating initial operating grants under this Act.

Consultation and education (C & E) is a basic ingredient in the community mental health center program. Such services are not generally reimbursable through third party payments, although some centers have been able to charge other community agency for C & E services. C & E services are preventive and facilitate the early detection of mental and emotional problems in children and adults. They benefit the mental health of the entire community, and as in other health programs, preventive mental health services represent an excellent investment of federal dollars.

By providing a grant program for this purpose, the bill ensures that all centers will offer C & E programs. It also maintains the overall quality of CMHC programs after Federal operating grants run out. Applicants for C & E grants must continue to meet the definition of a community mental health center under this bill (other than the requirement regarding C & E programs). Thus, once Federal funds are no longer supporting the direct services of a community mental health center, that center will continue to offer comprehensive services, maintain linkages with other health and social service agencies, and serve the needs of its catchment area. Without some continued form of Federal involvement it is probable that many CMHCs funded under the Act would deteriorate substantially once Federal funds are cut off. Having made this investment and stimulated the development of these comprehensive programs, the Committee intends to ensure that they continue to operate as comprehensive care centers.

These grants could also have a very important impact on the quality of other community mental health programs—programs funded originally without Federal funds and which do not now meet the standards set in either the current law or the proposed legislation. These entities could be State funded programs, or private, nonprofit organizations. The C & E grant could be an incentive for these agencies to upgrade their programs to the level required under this bill, and bring them into the Federal system ensuring they meet the minimum national standards for all CMHC programs.

Inasmuch as consultation and education services are not reimbursable by third party payors, nor likely to be covered by national health insurance, and return only a portion of their costs when paid for by recipients, they are most vulnerable to erosion as Federal and other funds decline. It is particularly important to ensure the viability of a community mental health approach by promoting the visibility and identifiability of consultation and education services.

Such visibility is best assured through an identifiable and separate grant program. One of the difficulties in developing consultation and education programs has been that the pressure of establishing direct clinical services has resulted in a relative neglect of the indirect services. Without special attention to consultation and educational programs, there is no real incentive for centers to develop well articulated and defined programs, particularly in the early years of operation.

Basically, consultation involves the provision of mental health assistance, by qualified personnel, to a wide variety of community agents and caregivers, including, but not limited to, schools, courts,

police, clergy, and health care personnel such as physicians and public health nurses. With case consultation, this may take the form of collaboration with community agents, enabling them to deal more effectively with certain of their clients who may be experiencing emotional difficulties. In the case of program consultation, the emphasis is not on an individual client, but on the planning and development of mental health related programs in a variety of community agencies. Such consultation may be reflected, for example, in the development of public school classes for emotionally disturbed children, or the development of mental health programs in industrial work situations.

The particular advantage of all forms of consultation is that the impact of mental health personnel is extended to groups of persons who might never reach the community mental health center. A school teacher better able to deal with underachieving or aggressive children, a physician better able to deal with the family of a person with a terminal illness, and a more humane and effective community approach for dealing with the emotionally disturbed offender are all reflections of an effective community mental health center consultation program.

The education program of the community mental health center has at least two major functions. First, its goal is to increase the visibility, identifiability, and accessibility of the community mental health center for all residents of the catchment area. A community mental health center cannot serve as an effective community resource if large segments of the population are unaware of its purposes, its functions, its location, or its relevance to community needs.

A second major goal of a community mental health center educational program is to promote mental health and to prevent emotional disturbance through the distribution and dissemination of relevant mental health knowledge. Materials on effective ways of dealing with depression, the mental health aspects of baby and child care, and the impact of life crises on mental health are all appropriate concerns of the "education" part of consultation and education.

The consultation and education service must be coordinated with all other center services. The service, for example, can have marked impact on the appropriate, effective utilization of the center and upon patient flow through the direct services. Through effective consultation and education, the center will receive more appropriate referrals, enable other caregivers to manage their clients more effectively, and enhance continuity of care, as well as extending service to underserved groups in the catchment area.

General Provisions Affecting Grants

The bill sets a number of application requirements for planning, initial operating, consultation and education, conversion, and facility grants, including a number of requirements designed to ensure that CMHC's become self-sufficient wherever possible.

The Committee bill requires that each CMHC must make more strenuous efforts to obtain reimbursements for direct services rendered to Medicare and Medicaid beneficiaries. The Committee is disturbed that less than 6% of all funds received by CMHC's in 1972 were derived from the Medicaid program even though over 42% of the patients served were in families with incomes of less than \$2,500 and almost

two-thirds had incomes of less than \$5,000. One factor contributing to the low level of Medicaid reimbursements, the Committee concludes, derives from the failure of many State Medicaid programs to include services provided by free-standing clinics in their state plans. In this regard, the Committee intends to give careful consideration to legislation proposed by the Administration which would make "clinic services" a mandatory part of each State's Medicaid plan. Positive action by the Congress on this proposal would substantially increase payments to CMHC's and enable a significant reduction in categorical funding.

The Committee is also concerned by reports that CMHC's are not receiving payment for services from those who are able to pay for part or all of the cost of treatment. In total, patient fees and insurance payments amount to less than 12% of total revenues. The Committee, therefore, has included a requirement that each center establish an equitable and reasonable fee system for services.

The Committee also wishes to emphasize that the federal CMHC grant program is not intended to subsidize other Federal third party payment programs, such as Medicare, Medicaid and the social services programs authorized under the Social Security Act. The Committee is disturbed by reports that the Secretary intends to require federally funded CMHC's to deduct their Federal grant under this Act, before calculating the costs of social services for reimbursement purposes. Such a procedure severely handicaps the CMHC's capability of achieving self-sufficiency and prevents the development of realistic accounting systems thus disrupting the CMHC's efforts to obtain other third party payments. Under the new legislation, CMHC's are required to bill social services, Medicare and Medicaid on the basis of the full cost of services. Thus, this HEW policy is in direct conflict with the provisions in this legislation.

Finally, the bill requires HEW to provide technical assistance and training in fiscal and program management to grant applicants. This assistance is intended to ensure that the operations of centers, particularly their financial management and cost-accounting procedures, are sufficiently improved to achieve maximum reimbursements through patient fees and third party payments. Although efforts to provide such technical assistance are now being expanded in the Department, this action is belated and has not yet proved to be effective. The Committee expects the Secretary to increase technical assistance to existing programs, while at the same time requiring that all new programs have sound fiscal and program management systems.

The Committee recognizes, however, that constraints to increasing reimbursements exist which are beyond the control of individual CMHC's to ameliorate.

1. Free-standing CMHC's are not certified as "providers" under Part A of the Medicare program.

2. Medicare and most private insurers reimburse centers for physician services but not for other program costs.

3. Third party payors discriminate against the psychiatric patient by severe limitations on the number of outpatient visits reimbursable under the policy.

4. A high percentage of CMHC patients have incomes too low to purchase insurance with adequate mental health benefits, but too high to qualify them for public medical assistance programs.

Until these constraints are eliminated and CMHC's improve their own capability to fully collect monies to which they are entitled, third party reimbursements will remain insufficient to cover the cost of psychiatric services delivered in CMHCs.

The Committee, in recognition of the underutilized opportunities available to CMHC's as well as the uncontrollable constraints facing them, has adopted the following position on non-Federal reimbursements:

1. Federal grant funds are to be viewed as supplementing reimbursements from third party insurers, State and local funds, patient fees and other Federal health care financing programs such as Medicare, Medicaid and Social Services under title XX of the Social Security Act.

2. Federal grant funds will not be used to supplant State, local, other Federal and non-Federal funds.

3. The Secretary may *not* disapprove an application or reduce the Federal grant level on the grounds of inadequate effort by the CMHC to obtain reimbursements unless the Secretary affords the CMHC the opportunity for a hearing and obtains the recommendations of the National Mental Health Advisory Council.

In addition, the bill proposes, as conditions for receiving grants, a number of requirements consistent with the "conditions of participation" required of institutional providers under Part A of Medicare.

These requirements are designed to emphasize the Committee's objectives that CMHC's become independent of Federal support in an orderly and reasonable manner without the precipitous and counterproductive cut-offs and reductions proposed by the Administration which disrupt normal operations and retard full growth and development.

Financial Distress

It is the Committee's view that some of the existing CMHC's will experience substantial financial distress upon termination of Federal support because Federal support provisions now do not decline evenly to low levels, the centers have made inadequate efforts to collect reimbursement for their services from third party payors, and third party reimbursements are often simply unavailable for the services. Therefore, the new legislation contains a provision for making grants to those centers which experience financial distress with requirements designed to assure that these grants are used by the centers in cooperation with the Secretary to make operational and financial reforms which will relieve the distress without curtailing services.

The Committee intends, through the financial distress grant mechanism, to maintain the quality of all CMHC programs during the interim period between termination of federal staffing or operating grants and improvements in third party payments.

Facility Assistance

The proposed legislation revises the provisions of the present authority for assistance for construction of facilities for CMHC's. The new construction authority is to be available to both presently assisted and new CMHC's, but in either case only those which meet the definitional requirements and provide the assurances to the Secretary required of CMHC's which seek operating assistance under the legisla-

tion. Construction is defined under the new authority to include the acquisition or remodeling of facilities, the leasing of facilities, and the initial equipping of facilities which are acquired, remodeled, leased or constructed with construction assistance under the new authority. Authority for new construction has been limited to CMHC's located in catchment areas of which at least a quarter of the residents are poor. Leasing of facilities is to be limited to a period of 25 years or less.

This new construction authority increases the options available to CMHC's for construction by giving them the option of acquiring, building, remodeling, or leasing a new facility whichever proves the least expensive and most expeditious. The Committee has been concerned in the past that construction represents a very expensive, long-term commitment of Federal dollars and wishes to emphasize that the new authority is designed to allow construction when a program needs a new facility but to assure that the construction is the least expensive and most expeditious possible for that facility. In order to assist the Secretary with achieving this goal the present requirements that construction projects be reviewed at the State level, and that funding go first to the higher priority projects have been continued.

State CMHC Plan Requirements

The present authority for CMHC's requires the States to prepare a CMHC plan, and makes some effort to assure that this plan is consistent with other State health plans. In the new legislative authority the Committee has strengthened the requirements for a State plan so that it is now clearly intended to be a statewide plan for CMHC's and comprehensive mental health services. In addition, a specific requirement has been included which requires the CMHC State plan to be consistent with the State's mental health plan under section 314(d) of the PHS Act, which in its turn is to be consistent with the State's comprehensive health plans under section 314(a) of the PHS Act. In addition, the State plan requirements have been written in such fashion that no assistance to CMHC under the new title will be available to any State until that State has an approved State plan in place. Once the State plan is in place a requirement has been included that any application for Federal assistance under the new authority must be reviewed and commented on by the State agency which prepares the State plan prior to the Secretary's action on the application. These various requirements are all designed to strengthen the mental health planning processes of the Federal, State, and local participants in the provision of mental health services and thereby to assure the most appropriate possible use of Federal CMHC monies. The present provision permitting the use of a fraction of construction allotments to defray State administrative costs has been continued so that the costs of these planning requirements will not prove burdensome to the States.

Evaluation of Community Mental Health Centers

The Committee received testimony from the General Accounting Office and other witnesses concerning the present inadequacy of NIMH programs for measuring the accomplishments of the CMHC program. The GAO reported that at most of the 12 centers reviewed in their study program evaluation efforts "were nearly nonexistent because NIMH and the centers have placed little emphasis on this

activity." Singled out for criticism were HEW's contracted evaluation activities, which the GAO charged "were of little value because . . . (the) long time frames needed to complete evaluation studies delayed results until after program decisions were made. Further . . . the quality of results were such that they were of little help in the decision-making process. Moreover, NIMH's plan to monitor center programs by site visit has been ineffective because procedures for carrying out such visits have not always been followed by NIMH personnel."

The Committee believes that sound administration demands that NIMH develop and maintain a knowledgeable staff to evaluate programs, provide recommendations on improving services to HEW and to Congress, and provide follow up technical assistance to the centers for both service delivery and program management. Thus, in addition to the requirement that each center collect and disseminate fiscal and program data, the bill requires each CMHC to utilize at least 2 per cent of the funds it receives through its operating grant for an evaluation of its program. Such evaluations must be drawn up in consultation with residents of the catchment area to make the evaluation more meaningful in terms of improving the services deemed by the community to be in need of improvement.

The Secretary is also required to obligate each year not more than two percent of the total amount appropriated under sections 203, 204 and 205 to provide to centers, directly through the Department, technical assistance for program management and for training in program management. The Committee expects NIMH will use a portion of these funds to improve its site visit programs.

The Committee bill also requires HEW to conduct two studies. The first, to set forth a plan for extension of CMHC services throughout the nation within five years. This requirement is intended to underline the fact that the Committee does not consider the CMHC Act as a demonstration program. It is the Committee's intent that within the next five years, the entire nation be served by an appropriate network of centers, generally assisted through the seed money provided for under this title. Since the present Administration has indicated that it feels the centers are a demonstration program which they do not intend to continue to support, the Committee feels it is necessary to require the Administration to submit a plan for the continued development of such centers.

Secondly, the bill requires HEW to submit within 18 months a report outlining national standards for care provided by CMHC's and criteria for the evaluation of CMHC services. Since the Committee intends to continue and expand Federal support for CMHC's it is appropriate to undertake the setting of standards and the development of evaluation criteria which will assure that this large investment of Federal funds is made in a program of uniformly high quality and efficiency.

RAPE PREVENTION AND CONTROL

Included within the legislation as Part D of the revised Community Mental Health Centers Act are provisions to establish a National Center for the Prevention and Control of Rape within the National Institute of Mental Health.

Background

According to the Uniform Crime Reports released by the Federal Bureau of Investigation, forcible rape is the fastest growing crime of violence in the United States; 51,000 females were the victims of forcible rape in the nation in 1973. This represents a 10 percent increase over 1972, and a 62 percent increase over 1968 figures. Expressed in terms of a victim risk rate, 47 out of every 100,000 females in the country were victims of rape in 1973, a 55 percent increase over the 1968 level. When the statistics of 58 core cities with populations in excess of 250,000 are considered, the victim risk rate approaches 100 per 100,000 females.

The FBI adds that forcible rape is "probably one of the most under-reported crimes" in the country. A recent survey by the Census Bureau for the Law Enforcement Assistance Administration indicates that forcible rapes may occur at rates between $3\frac{1}{2}$ to 9 times greater than those reported to police departments and hospitals. The FBI attributes this under-reporting to "fear and/or embarrassment on the part of the victims." In addition, there is evidence that known legal difficulties associated with the prosecution of an alleged rapist inhibit reporting. The FBI report indicates that only 51 percent of reported rapes in 1973 were cleared by arrests; only robberies had a lower clearance rate. Of the adults arrested, 76 percent were prosecuted for this offense. Of the cases prosecuted, 47 percent resulted in acquittals and/or dismissals; 36 percent were found guilty of the offense; and 17 percent were convicted of lesser offenses.

It is not infrequent that a woman who reports a rape has to contend with the societal assumption and suspicion that she may have provoked the attack, or that, because she has survived the rape, she willingly complied with the aggression. The rape task force report for the Public Safety Committee of the District of Columbia. City Council has described the predicament which often confronts the victim of rape:

A "good" woman is chaste—for her, rape is a "fate worse than death" and so she would fight to the death to avoid it. In such a situation extrinsic evidence of the rape is plentiful—bruises, wounds and screams. If there is not such extrinsic evidence—if she would rather be raped than die—then society assumes she consented or at least enticed the man into raping her. Only in this crime does society demand that the victim choose between the risk of serious injury or death and being able to obtain the conviction of the criminal. Thus for generations, society had the death penalty for rape and stringent burdens of proof to prevent conviction unless the woman "really" rejected.

The District of Columbia task force report added that—

Prosecutors and judges who acknowledge the problem, see the law of rape as a confluence of myth, reality, social taboos, anachronism, and . . . as a patina of sexual psychology as interpreted by police, lawyers, and judges.

Compounding these problems for the victim of rape are difficulties which she may encounter in securing necessary and adequate medical attention and treatment. There are reports that some physicians have

refused to provide treatment and examination to the victim of rape because they do not wish to appear in court. When, and if, the victim finally receives medical attention, it may be provided by a person untrained in the sensitivity and understanding required to mitigate the emotional trauma of the victim; or by a person who fails to provide venereal disease and pregnancy protection and who does not refer her for follow-up treatment. The victim of rape may later discover that her legal case was weakened at the hospital because the examiner failed to use available scientific investigative techniques in their entirety.

For these various reasons, the Committee believes that a thorough understanding is required of the nature and scope of rape, the impact of this crime on the victim, her family, and the rest of society, and the implications of the present method of treating victims for the status of women in general. The Committee notes that present methods of treating victims and handling alleged offenders are associated with many difficult and unsolved problems that arise from rape laws themselves. The Committee therefore seeks in the proposed legislation described in detail below to provide for a comprehensive examination of the many issues involved in forcible rape and thereby to elevate to a higher priority the discovery of methods for preventing rape as well as the provision of better treatment, justice, and redress for victims of this crime.

Intent of legislation

The proposed legislation would authorize the establishment of a National Center for the Prevention and Control of Rape within the National Institute of Mental Health. This Center would conduct research into the legal, social, and medical aspects of rape, and in so doing, examine the effectiveness of existing Federal, State, and local laws dealing with rape; the relationship, if any, between traditional, legal, and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape; and the treatment of the victims of rape by law enforcement agencies, hospitals, prosecutors, and the courts. Furthermore, in its investigations the Center would expand and intensify research into the causes of rape, including such aspects as social conditions which encourage sexual attacks and motivations of offenders. The Center would also examine the actual incidence of forcible rape as compared to the reported cases; the effectiveness of existing private, and local and State government, education and counseling programs designed to prevent and control rape; and sexual assaults in correctional institutions.

The legislation would also charge the National Center with the responsibility of disseminating information and providing training materials related to rape to State and local governments, voluntary organizations, and professional associations which are engaged in or intend to engage in efforts to address the problems encountered in the treatment of rape victims and the administration of justice related to rape and other criminal sexual assaults. The establishment of an information clearinghouse within the Center would correct the significant absence of a central repository of information on rape research as well as on prevention, treatment, and control programs in the country. It is intended that all communities have access to any information compiled by the Center which might assist them in devel-

oping more efficient methods for dealing with the problems outlined above.

Much of the current activity involving rape prevention, treatment, and control is supported solely by State, local, and voluntary funding sources. The Committee acknowledges that this locus of activity is the most effective and desirable for dealing with the problems involved in forcible rape, but believes, at the same time, that the Federal government can and should encourage and support the activities indicated above by providing technical advice, and by funding research and demonstration projects to discover new and more effective means of carrying out State and local programs. The legislation authorizes for these purposes \$7 million for fiscal 1976 and \$10 million for fiscal 1977.

Other provisions of this title of the bill would require the Center to transmit annually to Congress, through the Secretary of HEW, a summary of the research activities of the Center, along with any recommendations for further action by the Congress. The legislation would also establish an advisory committee which would advise, consult with, and make recommendations to the Secretary on matters relating to rape prevention and control.

TITLE IV.—MIGRANT HEALTH

BACKGROUND

National attention began to focus on the plight of the American migrant agricultural workers during the early 1960s. A scattered and mobile population, the migrant agricultural workers and their families rarely remained in an area long enough to identify local health care services. At the same time, they were more often than not forced to live under conditions that presented serious danger to personal and public health.

In recognition of this situation, the Congress enacted the Migrant Health Act of 1962 (Public Law 87-692) which amended the PHS Act by the addition of section 310, providing authority for Federal grant support to health clinics that provided services to domestic migratory farm workers. The original legislation authorized \$3 million in grant support, of which \$750,000 was appropriated. This limited funding, combined with the limited authority included in the Act made it impossible to develop the resources necessary to effectively serve the personal health care problems of migrants and their families.

With assistance for personal health services essentially precluded by limited appropriations, funds were instead used to support ongoing preventive health programs such as immunization, health education, and environmental safety programs conducted by State and local health agencies. This pattern of support for existing public health services continued through the first three years of the program. A Congressional re-evaluation of section 310 activities early in 1965 indicated the inability of the program to meet the personal and family health care objectives of the original Act.

As a result, the Community Health Services Extension Amendments of 1965 (Public Law 89-109) included provisions amending section

310 that provided broader authority and increased authorizations to support migrant health projects. In addition to authorizations during fiscal year 1966 that more than doubled those of the first year of the program and tripled them by fiscal 1968, the legislation also authorized the use of section 310 funds for necessary hospitalization of migrants. With a renewed Federal commitment and increased funding, it became possible to begin supporting projects designed to actually deliver health care services to migrants.

In 1968, Congress passed the Health Services Amendments of 1968 (Public Law 90-574) which included extension of section 310 authority through 1970 and increased the authorization level for project support. Thus, during the period between 1968 and 1970 the program was able to increase the number of migrants receiving Federally supported personal health services from 85,000 to 102,000.

Prior to the expiration of legislative authority under section 310 in 1970, the Congress renewed the migrant health program with the enactment of Public Law 91-209. These new amendments not only extended authority through fiscal 1973 and provided a major increase in authorizations for the program, also made two important changes in the parameters of project support. First, authority was expanded to allow support to projects providing health services to resident seasonal farmworkers and their families living in communities which experienced seasonal influxes of migrant farmworkers. Second, a new provision was introduced which required consumer involvement in the migrant health projects receiving support. The Department of Health, Education, and Welfare issued regulations governing the award of grants under this new authority in 1972, and in May 1973, the Department issued a complete set of regulations and program guidelines.

With the expanded eligibility there has been a steady increase in the number of farmworkers and their families being served. For example, in 1972 there were 460,000 patient visits; it is estimated that in 1974 there were approximately 630,000 patient visits.

Moreover, the increased Congressional support, both in terms of the authorizations (and subsequent appropriations) and the broadened authority provided to the migrant health program, has enabled the development of projects that genuinely provide the critically needed health services originally intended. From the rather limited scope of services provided by the first Act in 1962, which relied heavily upon existing health care mechanisms to provide the few services possible given the limited appropriation, the program now offers a wide variety of health services through approximately 100 projects actually developed under the Act. Of equal significance, the program now has a mandate to actively involve both consumer and community participation in the development and delivery of these services.

The services now provided through the program include both full-time centers providing a wide variety of comprehensive health services, and specially scheduled clinics offering categorical services which are supplemented by referrals. The program has supported demonstration projects to expand hospital coverage for migrant workers and explore the delivery of care through prepaid capitation. Experiences

such as these will provide invaluable data as the Congress moves toward the enactment of a program of national health insurance.

With the expiration of the migrant health authority in June, 1973, Congress passed Public Law 93-45 which provided a one year extension of the authority including an authorization of \$26.75 million. Since June 1974, authorization for these programs has been extended through continuing resolutions on appropriations at \$24,000,000. A complete budget history for the program is provided in table 14 which follows.

TABLE 14.—HEALTH SERVICES FOR DOMESTIC AGRICULTURAL WORKERS, PUBLIC HEALTH SERVICE ACT, SEC. 31
(In millions of dollars)

Fiscal year	Authorization	Budget request	Appropriation	Obligation	Outlays
1970.....	15,000	12,000	15,000	14,893	11,172
1971.....	20,000	14,000	14,000	13,997	14,581
1972.....	25,000	17,000	17,950	17,864	13,709
1973.....	30,000	23,750	23,750	23,750	17,716
1974.....	26,750	23,750	23,750	23,750	22,639
1975.....	¹ 24,000	24,000	¹ 24,000	(24,000)	(23,094)
Total existing law.....	140,750	114,500	118,450	(116,254)	(102,871)
1976.....	39,000	19,200			
1977.....	44,000				
Total H.R. 4235.....	83,000				

¹ H.R. 4925 provides for a simple extension of existing authority for fiscal year 1975. The migrant health program is presently being funded at the indicated level under continuing resolution.

With a funding level of \$24,000,000, the program now supports health service projects at major migrant locations throughout the United States. The dimensions of the current program and its development over the past two years are summarized in table 15.

TABLE 15.—CURRENT DIMENSIONS OF THE MIGRANT HEALTH PROGRAM

	Year		
	1972	1973	1974
Program scope:			
Number of projects.....	101	102	103
Target population.....	¹ 3,000,000		
Patient visits.....	460,000	600,000	630,000
Costs:			
Appropriation.....	\$17,950,000	\$23,750,000	\$23,750,000
Average project costs.....	177,722	208,330	228,365
Cost per person per year (based on visits).....	69	70	67

¹ During each year.

The requirement to extend participation to consumers in actual program activities has increased awareness of migrant health needs within the Department of HEW and among residents of areas where migrants work. With this increased awareness and increased appropriations, the migrant health program has been able to move into new areas and to more vigorously attempt to resolve problems that have long beleaguered those providing health care for migrants.

These problems have principally been in the areas of: hospitalization, prepayment, Medicaid coverage, and migrant camp sanitation.

The problem of hospitalization has persisted in part because the Federal funds available for migrant health projects have primarily been limited to the development of ambulatory care programs. Normally less than \$500,000 is allocated each year for hospitalization of migrants, primarily to cover emergency hospitalization. To determine just how significant this problem is, the migrant health program is currently supporting a demonstration activity designed to: study the frequency of hospital use by age, sex, diagnosis, and other variables; analyze hospital services used by migrants; analyze the total and component cost of hospital care; study pre- and post-hospitalization use of ambulatory care; and compare the migrant hospitalization experience with that of other low-income groups.

In the area of prepayment, the migrant health program supported four demonstration projects during fiscal 1973. Three projects conducted in communities to which workers migrate for only a limited season encountered an unwillingness of providers of prepaid services to participate, and difficulties in providing effective referral services. A fourth project in an area where migrants reside for periods of 8 to 10 months has enrolled more than 750 migrants through a contract with a private health insurance program. The success of this program has led to future plans to extend coverage to approximately 3,000 migrants and their families in the area and to establish capitation programs for migrants in other areas where migrants reside on a relatively long-term basis.

At the present time numerous barriers exclude migrant participation in Medicaid. These include lack of coverage under the definitions of "categorically or medically needy", the absence until recently of a Medicaid program in Arizona—a major migrant State, strict application of the "intent to reside" regulation, resistance among migrants to use of Medicaid because of the welfare stigma, and various legal and administrative complexities. Some migrant workers have been able to participate in health insurance programs that increase the medical and health care benefits available to them; however, most migrants still lack the benefits of insurance coverage.

Another problem facing migrant farmworkers has been the poor quality of their living conditions. Migrant camp sanitation has long been a great concern within the migrant health program and among the migrant communities. In 1973, a typhoid outbreak at a migrant labor camp in southern Florida focused national attention on this problem and the need to place greater emphasis on it through existing State and Federal programs. One principal result of this episode was a two-part initiative within the Department of Health, Education, and Welfare to train migrant project personnel to identify environmental and sanitation problems and to enable State agencies to assure high standards of sanitation in labor camps.

This description of the migrant health program to date suggests that the program has made an excellent start at providing needed services to migrant workers with the limited resources available to it. The Committee is in fact concerned that given the profound health needs of our migrant workers and the success of the program to date, the administration has not seen fit to seek specific continued authority for the program. However, after its review of the program the Committee has decided to revise the legislative authority to give increased

focus to the provision of comprehensive services in migrant health centers serving high migrant impact areas, and to programs to improve the healthfulness of the environment for migrants, and has chosen to substantially increase the authorizations for the program so that it can resume reasonable expansion.

PROPOSED LEGISLATION

Definition of Migrant Center

The revised migrant authority provides a new program of support for migrant health centers. A migrant health center is defined as an entity which provides certain health services to migratory agricultural workers and their families, and seasonal agricultural workers (those workers who have permanent residence and work in agriculture on a seasonal basis in the area of that residence) if such service to seasonal workers or family *may* contribute to improved health conditions for those workers. Present law provides that health services be provided for *domestic* migratory workers and to seasonal workers when such service *will* contribute to better health conditions for the migrant worker. The Committee has deleted the term "domestic" as vague and because it does not believe the Department of HEW should be attempting to determine the citizenship of migrant workers. The bill also defines the term "migratory agricultural worker" as an individual whose principal (i.e., over 50 percent) employment is in agriculture on a seasonal basis, who has been so employed within the last two years, and who establishes a temporary abode for the purpose of this employment.

Primary Health Services

A migrant health center is required to offer a number of services. First, such a health center must provide specified primary health services. These services include basic diagnostic and treatment services and other services rendered by physicians. Where feasible, these functions may be performed by physicians' assistants and nurse clinicians. Services performed by these personnel shall always be under the general supervision of a physician (although this does not mean that the physician must be physically present at the center) and shall not be permitted in contravention of any appropriate State statute. This provision is intended to permit optimum use of non-physician providers when appropriate so that physician services can be maximized.

Also included as primary health services which must be offered by the centers are diagnostic laboratory and radiologic services. By radiologic services, the Committee intends that diagnostic radiologic services (i.e. X-ray services) *must* be provided by a migrant health center, and that therapeutic services (i.e., the treatment of disease by radiation) *may* be offered as part of a supplemental service.

The term "primary health service" also includes preventive health services. The legislation stipulates that these services should include children's eye and ear examinations designed to determine the need for vision and hearing correction, perinatal services, well-child services and family planning services. Perinatal services and well-child care are not to be viewed as being restrictive, but rather as requiring a full range of maternity and infant care by appropriate providers.

Family planning services are intended to cover routine family planning consultations, examinations and other related family planning services normally provided in a physician's office. By specifically mentioning these services, it is not the intent of the Committee to exclude other preventive health services as being primary health services either generally or as needed in particular areas. In fact it is hoped that other services which can be shown to be cost-beneficial (such as tonometry) will be required of the centers.

Emergency medical services constitute another category of primary health services. This item is not intended to be read so restrictively as to be applicable only when there is a matter of life, death or severe urgency, nor does it mean that a migrant center must be in a position to treat a potential emergency of an unusual nature. Appropriate arrangements should be established so that the center can reasonably assure access to necessary health care for migrants in the case of any serious emergencies.

Preventive dental care for all age groups is also required to be provided through the center as a primary service. This does not mean that each center must have a full time dentist, but at a minimum, each should have arrangements so that the services of a dentist are available. Much of the preventive dental service may also be performed, as appropriate, by other health professionals. Thus, for example, preventive dental services should include as a minimum topical fluoride applications, instruction in oral hygiene and periodic plaquing and scraping, all of which can be provided without a dentist.

Finally, with respect to primary services, the bill requires that the center provide adequate transportation to assure appropriate use of the center by migrants. The services available at a center will be useless if the migrant population to be served is unable to find needed transportation. Each center should implement a plan to assure that transportation is not a barrier to a migrant receiving needed medical attention.

Other Required Services

In addition to offering primary health services as described above, a center shall be required to provide referral services with respect to a broad range of supplemental services. If it is appropriate and within the budgetary capability of a center, the services provided on referral (and necessary costs associated therewith) should be paid for by the program. Services which are a necessary adjunct to the provision of primary services shall also be provided by the centers. It is recognized that the course of treatment or ancillary procedures needed to treat particular conditions may vary from area to area or among population groups. Therefore, discretion is allowed in determining which supplemental services shall be provided at which centers. The provision should not be interpreted to require that the full range of supplemental services be provided merely because they would be useful or desirable in providing primary care. The criteria in interpreting this clause should be whether or not the primary service can reasonably be carried out without the provision of the particular supplemental services. Only if the primary service cannot reasonably be carried out in the absence of the supplemental service should that supplemental service be considered as a mandatory function of the center.

Centers are also required to offer a broad spectrum of environmental health services relating to the detection and alleviation of unhealthful conditions associated with water supplies, sewage treatment, solid waste disposal, rodent and parasitic infestation, sanitation in the fields, housing, and other related environmental factors. Migrant centers should not duplicate the functions of other agencies or establish standards relating to the environment where standards already exist but should monitor the enforcement of existing standards in their areas. The center should, of course, treat any diseases or symptoms arising from unhealthful conditions and shall do all in its power to seek correction of unhealthful conditions through notification of appropriate agencies and the public of the existence of such conditions and working with those agencies in attempting to alleviate the conditions.

Related to the requirement to provide environment health services are requirements for the centers to conduct infectious and parasitic disease screening and control and to attempt to prevent accidents including accidental pesticide exposure. These requirements are mandates to migrant health centers to inform and educate migrant populations on these matters and to do what is within their capabilities as health providers to achieve alleviation of any problems in this regard.

The environmental health services and related services mentioned above are to be provided "as may be appropriate for particular centers." This is not a grant of blanket discretion for the Secretary in administering the program to waive the requirement for their provision. These services should be available unless he affirmatively finds they are inappropriate for a particular center.

The final mandatory service for a migrant health center is that it must provide information on the availability and proper use of health services. This provision covers not only outreach services but also instruction and training with respect to routine good health practices. Dissemination of information on the availability of services through the center and elsewhere should be vigorously pursued so that services will, in fact, reach those in need. It is the clearly expressed intent of the Committee that such services should be designed to overcome any language and cultural barriers.

Provision of Services

The services of the center may be performed through its own resources or through contracts or cooperative arrangements with public or private entities. The provision will afford the Secretary the opportunity to best utilize available resources and avoid duplication or waste. However, to the extent possible and appropriate, the center should develop its own capabilities and should not be unduly dependent on outside sources. The centers should not enter into such cooperative arrangements unless there is adequate assurance that such an entity can provide the needed service in a timely manner, is reasonably accessible for the migrant population to be served and can provide the needed service on a regular basis.

Supplemental Services

Supplemental services are defined to include a broad range of services which are not ordinarily provided by migrant health centers. The centers will, however, be required to provide prompt and efficient

referral to appropriate providers of these types of services and, if appropriate and feasible, reimburse those providers for any such services. Supplemental services include:

- All generally accepted hospital services;
- Home health services;
- Extended care facility services;
- Rehabilitation (including therapy) services and long-term physical medicine;
- All dental services reasonably needed to preserve health;
- Mental health services (including services of psychiatrists and appropriate psychological services);
- Vision services (including eyeglasses, as appropriate);
- Allied health services;
- Pharmaceutical services (including prescription drugs and appropriate over-the-counter drugs);
- Public health services (including nutrition education and social services);
- Health education services (including training in routine health care); and
- Services which promote and facilitate optimal use of health services described in the legislation including a comprehensive outreach program.

High Impact Areas

The new migrant authority is focused for maximum efficiency on high migrant impact areas. "High impact area" means a county or other subdivision within a State which has at least six thousand migratory agricultural workers and their families and/or seasonal agricultural workers (and their families) residing therein for more than two months in any one calendar year. Grants for the establishment of migrant health centers are restricted to centers which intend to service high impact areas. Additionally, funds for grants to provide certain services in areas which are not served by a migrant health center and which do not qualify as high impact areas are restricted to thirty per centum of the funds authorized to be appropriated in fiscal 1976 and twenty-five per centum of those for fiscal 1977.

Grants and Contracts for Service to Non-High Impact Areas

The Secretary is authorized to support the provision of certain health services to agricultural workers (migratory and other) and their families (including seasonal workers and their families when health service to these workers may contribute to improved health of agricultural migratory workers) in areas not served by a migrant health center and in which less than 6,000 migratory agricultural workers reside. These services that may be provided to these individuals include the following:

Emergency health care:

Primary health care (as defined in regulations of the Secretary but which should at a minimum include diagnostic and treatment services of a physician or other appropriate health practitioner under the general supervision of a physician);

Provision of other primary health care through arrangements with existing health facilities; and

Other activities designed to improve the health of agricultural migratory workers and their families. This service may extend to other agricultural workers if the activity will lead to or contribute to an improvement in the health condition of the agricultural migratory worker. A project in such an area may provide one or more of these services and is not required to perform all such services to qualify for a contract or grant. It is preferable that all services be provided but the Secretary may, at his option, fund projects where less than all services are provided.

Priority

The bill requires the Secretary to assign priorities for the provision of assistance for programs and projects to high impact areas, and other areas only where appropriate. The highest priority for assistance is to be assigned to areas in which the greatest number of migratory agricultural workers and the members of their families reside for the longest periods of time. Additionally, the bill requires that no application for migrant health centers or projects in areas in which only seasonal agricultural workers reside may be approved unless grants have been provided for all approvable applications for centers or projects in areas with migratory agricultural workers. These provisions clearly emphasize the intent of the Committee to first meet the needs for health care services of migrant workers.

Planning and Development Grants

In accordance with the priorities described above, the bill authorizes the Secretary to make grants to public and nonprofit entities to plan and develop migrant health centers to serve both migratory and seasonal agricultural workers and their families in high impact areas.

In those high impact areas where fewer than 6,000 migrant workers reside, however, the Secretary may determine whether a complete center is feasible and reasonable. Only high impact areas with 6,000 migrant workers are required to be served by a center.

In planning and developing a program, the grantee should:

1. assess the need that the workers (and the members of the families of such workers proposed to be served) have for primary health services, supplemental health services, and environmental health services;
2. design a migrant health center program for such workers and members of their families, based on such assessment;
3. make efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and
4. initiate and encourage continuing community involvement in the development and operation of the project.

No more than two planning and development grants may be awarded to applicants in order to assist them in meeting costs of (1) developing primary, supplemental, environmental health and information services, including additions to services already offered; (2) developing the resources and techniques necessary to achieve compliance with the program operation and management conditions attached to operating grant approval; (3) acquiring, remodeling and renovating existing facilities including the cost of amortizing the

principal of, and paying the interest on loans and (4) training in program management.

The bill, also authorizes the Secretary to award planning and development grants or enter into contracts with public and nonprofit entities for the planning and development of projects for the provision of certain limited health services in areas where no migrant health center exists, and where less than 6,000 migratory workers and families reside for more than two months. Grants and contracts in such areas may cover the costs of facilities and training as in high impact areas but are limited to only one grant or contract for each project.

Operating Grants

The bill authorizes the Secretary to award grants to public and nonprofit private entities for (1) ongoing operation of migrant health centers in high impact areas and (2) projects which intend to become centers serving high impact areas.

The bill also authorizes operating grants and contracts to provide certain limited services in low impact areas or to projects in high impact areas but where less than 6,000 migratory workers and their families reside for more than two months. However, if an area has 6,000 migrant agricultural workers (including their families) for at least two months per year it must be served by a migrant health center, provided an application has been received and approved from such an area.

The Secretary is authorized to award no more than two operating grants to projects in high impact areas which intend to become migrant health centers which cannot meet all of the service or application requirements. The Committee intends that the period of the grant or grants for developmental purposes be limited, as the Secretary may prescribe by regulations, to the time necessary to become migrant health centers and meet all of the requirements for becoming a migrant health center. In no instance shall a project of this type receive more than two years of support under a planning and development grant or operating grant or a combination of the two types of grants without becoming reclassified as a fully operational migrant health center.

Operating grants and contracts may cover the cost of acquisition and modernization of existing buildings including principal and interest payments on loans and the cost of training in project management and in provisions of services by projects. It is the intent of the Committee that costs covered be more limited for areas where fewer migratory workers reside.

Application for Grant and Contract Support

Planning and development and operating grants are authorized to be made by the Secretary based on the receipt and approval of an acceptable application as prescribed by the Secretary.

All applications for grants which include acquisition, expansion, modernization or renovation of facilities should contain a description of the site; plans and specifications; assurances as to title; and reasonable assurances that workers employed with respect to such work will be paid not less than prevailing wages for the locality as determined by the Secretary of Labor under the Davis-Bacon Act.

It is the intent of the Committee that the Secretary receive satisfactory assurance that grants for migrant health centers and projects will be used to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds (including third-party health insurance payments) available to the area and not supplant such funds.

In addition, the Committee intends that the Secretary should determine, in consultation with the appropriate State and local health planning agencies, that the services to be provided by centers and projects will constitute an addition to, or significant improvement in, the quality of services available in the area.

Operating grants for centers or projects which intend to become centers in high impact areas are to be awarded based on applications, as specified in regulations issued by the Secretary, which contain assurances as described in the bill regarding accessibility, continuity, quality assurances, the confidentiality of patient records, governing boards, financial responsibility, fee schedules, collections, reporting, and catchment area review.

Regarding third-party payments, it is the Committee's intent that centers will be reimbursed for the fair and reasonable cost of the provision of services regardless of the source of funding for center activities (including Federal project grant support). Any other determination of a lower reimbursement rate by States or the Secretary would be directly contrary to both the Committee's intent and the Secretary's expressed objectives that these programs develop an increasing degree of self-sufficient management capability and an increasing degree of independence from direct Federal project grants.

Contracts to Assist States

The Secretary is also authorized to enter into contracts with public and non-profit entities to assist the States in the implementation and enforcement of acceptable environmental health standards for migrant camps including sanitation standards and applicable Federal and State pesticide control standards. Such contracts may also be used to conduct projects and studies which will assist the States in assessing problems related to camp and field sanitation, pesticide hazards and other environmental health problems faced by agricultural migratory and seasonal workers.

This authority is not intended to duplicate the work or functions of the Environmental Protection Agency, the Occupational Safety and Health Administration, or the Agriculture Department. Any contracts awarded under this section should be made only after appropriate consultation with these agencies. Although this section could be broadly interpreted to include problems of toy safety (other environmental health problems) or pesticide residues in foods (pesticide hazards), the purpose of the section clearly does not extend to these areas of concern, and the implementation of this section should be targeted toward the unique environmental problems of agricultural migratory workers.

Authorization of Appropriations

Planning and Development Grants and Contracts.—The bill authorizes \$4,000,000 for fiscal year 1976 and \$4,000,000 for fiscal year 1977 for planning and development grants and contracts.

Operating Grants and Contracts.—The bill authorizes \$30,000,000 for fiscal year 1976 and \$35,000,000 for fiscal year 1977 for operating grants and contracts. No more than 10 per centum of funds appropriated for any year for operating grants may be used for contracts to assist States with environmental health matters.

In addition to authorizations for Planning and Development and Operating grants and contracts \$5,000,000 in fiscal year 1976 and \$5,000,000 in fiscal year 1977 is authorized to cover the cost of in-patient and out-patient hospitalization services.

No more than 30 percent of funds appropriated for Planning and Development and Operating grants and contracts for fiscal year 1976 or 25 percent for fiscal year 1977, or 90 percent of the previous years' total program funding for these types of projects, whichever is greater, may be used to fund projects in low impact areas.

National Advisory Council on Migrant Health

The legislation requires the Secretary to appoint and organize a 15 member National Advisory Council on Migrant Health within 120 days after the enactment of the new section to advise, consult with, and make recommendations to the Secretary on matters concerning the migrant health program. Membership of the Council is to include a minimum of 12 persons who are also members of the governing boards of migrant health centers or other entities supported under section 319; of these 12, at least nine are to be chosen from among such members who are being served by centers or other grantees and who are familiar with the delivery of health care to migratory agricultural workers and seasonal agricultural workers.

Migrant Workers' Housing

A great deal of anecdotal information is available on the inadequacy of migrant living conditions. In addition, preliminary surveys of a limited sample of migrant labor camps have shown major deficiencies in sanitary conditions. Finally, the recent typhoid epidemic at Homestead, Florida, dramatically identified the potential for disastrous consequences of poor sanitation. However, to date, there has been no complete, empirical survey of the conditions in migrant labor camps.

Therefore, the legislation requires the Secretary of Health, Education, and Welfare to conduct or arrange for a study of the quality of housing available to agricultural migrant workers during employment, the effect of deficiencies of such housing on the health of such workers, and Federal, State and local government standards respecting such housing. The study is to be completed and a report of findings and recommendations is to be submitted to this Committee and the Labor and Public Welfare Committee of the Senate within eighteen months after enactment of legislation making appropriations for such study.

TITLE V.—COMMUNITY HEALTH CENTERS

BACKGROUND

To address the need for innovation in the provision of health services the Congress added section 314(e) to the PHS Act in the Comprehensive Health Planning and Public Health Service Amendments of 1966 (Public Law 89-749). The new section 314(e) provided broad authority to fund project grants for the development of health serv-

ices (and related training) by either public or nonprofit private entities. The projects, which were to be funded only after receiving the comments of the local areawide comprehensive health planning agency and after being determined to be consistent with State health plans, were to focus on providing services to meet health needs of a particular population or geographic region, or on public health problems with special regional or national significance. Additionally, this subsection also authorized support for projects which were aimed at developing and supporting, for an initial period, new programs of general public health services. Also included in the original law creating section 314(e) were provisions for support of studies and demonstration projects designed to develop new methods or improve existing methods of providing health services.

Before any funds had been appropriated under section 314(e), it was amended by the Partnership for Health Amendments of 1967 (Public Law 90-174). These amendments transferred authority for support of studies and demonstrations to section 304 of the PHS Act (the authority for health services research) and provided that the training funded under 314(e) had to be related to services provided by the project receiving funds. The amendments also extended section 314(e) for two years (until June 30, 1970), increased the authorization, and required one percent of any appropriations under 314(e) to be used for evaluation.

With the transfer of study and demonstration projects and the limiting of training to service related matters, the focus of the subsection became the support of ambulatory or comprehensive health care programs serving areas with scarce or non-existent health care services and populations with special health needs. In July, 1968, the Secretary of HEW issued a policy statement calling for the development of a Comprehensive Health Services program by the Department. In the first year that appropriations were available, eight Neighborhood Health Centers (NHCs) based on the model initiated by the Office of Economic Opportunity were funded. One year later, in 1969, 18 such centers were receiving a total of \$10.4 million in support. In 1970, thirteen NHCs initiated by the Office of Economic Opportunity were transferred to the Department of Health, Education, and Welfare. This transfer provided the impetus for an increased appropriation authorized under section 314(e). The increasing number of comprehensive or ambulatory health centers is traced in Table 16. A budget history for programs funded under section 314(e) is outlined in Table 17.

TABLE 16.—314 (E) PROJECTS FOR COMPREHENSIVE HEALTH CENTERS NUMBER AND TYPE OF FEDERAL PROJECTS SUPPORTED

	Total	Centers		
		Neighborhood health centers	Family health centers	Community health networks
1968.....	8	8		
1969.....	18	18		
1970.....	43	43		
1971.....	46	46		
1972.....	96	55	41	
1973.....	106	67	39	
1974.....	157	104	39	14
1975.....	157	116	30	11

TABLE 17.—PROJECT GRANTS FOR HEALTH SERVICES DEVELOPMENT, PHS ACT, SECTION 314(e)

[In millions of dollars]

Fiscal year and program area	Authoriza- tion	Budget request	Appropri- ation	Obligation	Outlays
1970:					
Neighborhood health centers and special projects.....				26.958	
Categorical programs.....				17.831	
Rodent control, rubella, and immunization.....				37.969	
Total.....	80.000	98.000	82.692	¹ 82.758	78.618
1971:					
Neighborhood health centers and special projects.....				64.515	
Categorical programs.....				10.795	
Health maintenance organizations.....				2.503	
Rodent control, rubella, and immunization.....				31.000	
Total.....	109.500	109.500	109.500	108.813	95.377
1972:					
Neighborhood health centers, special projects, and family health centers.....				99.060	
Categorical programs.....				7.312	
Health maintenance organizations.....				3.479	
Rodent control, rubella, and immunization.....				24.787	
Total.....	135.000	106.400	135.000	134.638	81.658
1973:					
Neighborhood health centers, special projects, and family health centers.....				110.250	
Categorical programs.....				0	
Health maintenance organizations.....				4.000	
Rodent control and lead-based paint projects.....				21.450	
Total.....	157.000	116.200	116.200	135.700	120.449
1974:					
Neighborhood health centers, special projects, family health centers, and community health networks.....				213.706	(161.355)
Categorical programs.....				0	
Health maintenance organizations.....				1.574	
Rodent control.....				13.100	
Total.....	230.700	216.100	217.100	228.380	
1975:					
Community health centers.....		196.648	196.648	(199.633)	(154.802)
Rodent control.....		13.100	13.100	(13.100)	
Total.....	² 230.700	209.748	² 209.748	(212.733)	
Total, existing law.....	942.900	855.948	870.240	(903.022)	
1976: Community health centers.....	220.000	155.190			
1977: Community health centers.....	240.000				
Total, H.R. 4925.....	460.000				

¹ Includes balance brought forward.² H.R. 4925 provides for a simple extension of existing authority for fiscal year 1975. The program is presently being funded at the indicated level under continuing resolution.

NHCs were developed to provide ambulatory health care to medically underserved populations. The services provided meet the general health needs of the population served rather than being oriented toward specific diseases. The centers attempt to coordinate Federal, State and local resources in a single organization capable of delivering both health care and related social services to a defined population. As developed, NHCs offer a broad package of benefits to their clients. In a 1973 financial inventory covering some 60 NHCs the following pattern of service was seen.

TABLE 18.—*Services offered by neighborhood health centers*

Service:	Percent of centers offering service
Medical	100
Laboratory	100
X-ray	90
Pharmacy	94
Mental health	76
Dental	96
Home health	83
Physical or speech therapy	26
Optometry	37
Sickle cell	40
Lead poisoning	31
Social and community services	94
Transportation	93
Training	81
Community organization	53
Research and evaluation	67
Environmental	29
Family planning	26

In 1971 new attention was focused on the need to complement the services being provided by NHCs primarily to low-income families in urban communities, with comparable services for the country's medically underserved rural population. The family health center (FHC) concept was developed as a potential means of meeting these needs. These centers are designed to provide a prescribed package of ambulatory health care benefits on a prepaid basis to an enrolled population residing in a defined area of medical underservice. A defined basic benefit package which each FHC project must deliver or arrange for, is available to each enrollee. This benefit package includes emergency medical services, physicians' services (except when provided by a psychiatrist), services of pediatric nurse associates or physician extenders, and other medical and health services such as outpatient services, outpatient physical therapy, and diagnostic laboratory and X-ray services. In addition, hospital and other non-ambulatory services are arranged for and coordinated by the FHC although grant funds are not used for these services.

Funding for these centers first became available in fiscal 1972. Since then, 39 FHCs have been initiated. Of these, 30 have become operational FHCs and none have become NHCs. Operational FHCs have finalized their benefit packages, developed organizational structures, and initiated enrollment activities. All centers are providing services on a fee-for-service and/or prepaid basis. It is estimated that in 1975, the 30 operational centers will serve approximately 105,000 people.

While the family health center concept was being made operational, the neighborhood health centers program was being expanded through the further transfer to HEW of NHCs administered by OEO. An agreement between HEW and OEO to provide for the transfer of an additional 19 NHCs was reached in 1972, bringing the total number of OEO centers transferred to 32; the transfer of the final 40 NHCs and 14 community health networks initiated by OEO was accomplished during fiscal 1974.

The most recent innovation in attempts to provide comprehensive health services is the development of the Community Health Network

(CHN), initiated under OEO and now administered by HEW as part of the interagency transfer agreement under 314(e). A CHN is designed as a multi-provider delivery organization, making use of health resources already existing in the community, including hospitals, outpatient departments, medical groups, free-standing ambulatory health care centers, medical group foundations and community health centers. The CHN is designed to provide individuals with access to a coordinated set of services paid for through a prepaid capitation plan. There are currently 11 Community Health Networks serving approximately 82,500 persons.

By fiscal 1973, funding for the few remaining special categorical projects receiving grant support under section 314(e) was either taken from other legislative authorities or phased out through integration into comprehensive public health projects. (See Table 17.) This left as the core of the health service projects funded under 314(e) the three community health center programs: neighborhood health centers; family health centers and community health networks. In fiscal 1975, 16 NHCs, 11 CHNs and 30 FHCs are supported with funds from 314(e).

Thus, a total of 157 community health centers now offer services to a projected target population of approximately 5.2 million people and will actually serve approximately 1,425,000 of these people during 1975. The total expenditure for these services will be \$293.5 million in 1975, including \$94 million from non-Federal sources (State and local governments and third-party reimbursements).

It is clear that the development of community health centers under section 314(e) has increased the availability of health care to many medically underserved communities. It is somewhat more difficult to assess the actual impact these new services have had on the health status of their communities, but the available evidence suggests that community health centers do have a positive impact on a community's health. For instance, a study published in the *New England Journal of Medicine* in 1973 showed that between 1960-70 the incidence of rheumatic fever dropped 60 percent in Baltimore communities receiving comprehensive health care services. The incidence of rheumatic fever in the rest of Baltimore was three times as high as in the communities receiving 314(e) funded services.

Another study conducted in Rochester, New York, and published in *Pediatrics* in 1973 indicated that the rate of hospital admissions for children using a NHC was half the rate for children in the same community who did not receive care from the NHC. Further, the average hospital stay for non-users was substantially higher than that for users of the 314(e) facility.

A recent study completed for five neighborhood health centers shows a decreased hospital utilization experience for persons served by such centers, as compared to the national average for a comparable time period. The average number of hospital days per person served per year was .76 as compared to a national average of 1.16. These figures represent a 34 per centum reduction in hospital days for persons served through those centers, an experience which is comparable to the hospital utilization experienced in a prepaid group practice setting.

Measures designed to allow a more complete and ongoing evaluation of the impact of community health centers have also been undertaken.

Beginning in 1971 HEW undertook contracts to provide external audits of NHCs. These audits which had been conducted for OEO NHCs beginning in 1968, had by 1974 been conducted at almost all NHCs funded under 314(e). An audit is conducted by a team of multi-disciplinary analysts who evaluate the quality of care provided and its impact on the population served, and provide recommendations for center improvement. The periodic external audits will in the near future be coordinated with ongoing internal audits, the methodology for which is being developed under contract for HEW. To further enhance the ability of HEW to monitor the fiscal responsibility of NHCs and more accurately evaluate program dimensions, a financial inventory was begun in the third quarter of 1972. Nearly 100 NHCs have also submitted information to an HEW data collection system, which has included uniform cost accounting information, data on participating physicians' patient loads, patient utilization patterns, and statistics on the dimensions and characteristics of the population served.

PROPOSED LEGISLATION

Based on its study of the authority provided by section 314(e) the Committee has come to several conclusions. First, it is clear that the 314(e) authority has been used well, although somewhat inappropriately, to develop a substantial program of comprehensive health services for medically underserved populations. The Committee feels that this program deserves continued Federal support and in the proposed legislation has authorized this support through the inclusion of a new specific authority for the support of community health centers (CHC) as described below. Second, the Committee feels that in recent years the 314(e) authority has been inappropriately used for a variety of often unidentifiable special, short-term initiatives on the part of the Department of Health, Education, and Welfare. In addition, on some occasions the Department has used the general authority available under 314(e) rather than specific authorities provided by the Committee for specific purposes. Since such a use of this general authority for a wide variety of short-term, special or non-recurrent purposes makes the authority difficult to oversee and makes it use unaccountable, the Committee has concluded that it is appropriate at this time to repeal it and replace it with specific new authorities for activities which the Committee feels need support.

Definition of CHC

A CHC is defined as an entity which provides primary health services, supplemental health services necessary for adequate support of primary health services, referral to providers of supplemental health services (any payment therefor as appropriate and feasible), environmental health services as appropriate and information on availability and proper use of health services. These services are to be provided to all residents of the area such a center serves.

Primary health services should be available and accessible in the area served by the CHC and in a manner that assures continuity. Although not specifically stated, other services described in the legislation should likewise be accessible and provide for continuity to the extent possible.

The term Community Health Center was chosen in lieu of Neighborhood Health Center to insure that the intent of the Committee that the new legislative authority also extends to Family Health Centers and Community Health Networks is clearly understood.

Primary and Supplemental Health Services

The primary and supplemental health services to be offered by a CHC are the same as for a migrant health center and the description of those services and comments thereon are equally applicable with respect to this section. In the case of diagnostic radiological services, however, it is intended for CHCs that, as appropriate, therapeutic services may be made available as a primary service. Also, immunization programs are considered an essential part of well-child services under primary health services.

Environmental health services to be provided as primary health services should be construed as those necessary to eliminate medical problems. It is not the intent of the Committee to require CHCs to offer the same range of environmental health services as required for migrant health centers where the need is significantly more acute.

The services may be provided directly through the CHC's own staff or supporting resources, or through cooperative arrangements with public or private entities. This provides flexibility so that existing facilities and resources may be utilized, but to the extent practical CHCs should develop their own independent capabilities. Arrangements should not be made unless there is adequate assurance that the entity is able to fully provide the needed services and will do so on an uninterrupted basis.

Governing Body

Each CHC is to have a governing body which shall meet once a month, shall establish the general policies for the CHC and approve selection of the director of the center. The governing body is required to be representative of consumers, health providers, and the general public. As in the case of the migrant health centers, the governing body should exercise other inherent powers of such a body and should be selected from persons residing in the area served.

Quality Assurance and Confidentiality

The CHCs will be required to develop organizational arrangements in accordance with regulations of the Secretary for an ongoing quality assurance program (including utilization and peer review systems).

Grants for the Establishment and Operation of Community Health Centers

Two programs of grant support to community health centers or to entities planning to initiate or develop into community health centers are provided. In both cases, grants can only be made to centers or entities which serve medically underserved populations.

First, the Secretary may award up to two grants to public and non-profit private entities with approved applications to plan and develop community health centers. Such grants may include the cost of acquisition and modernization of existing buildings including the cost of amortizing the principal of and paying the interest on loans. The project period is not to exceed two years.

Second, the Secretary may make grants to CHCs to cover the costs of ongoing operations, and to public and nonprofit private entities to cover the costs of providing primary and supplemental health services, related health services and management training. There is no limitation on the number of operating grants that a community health center may receive if it meets all the conditions of grant awards, but a public or private nonprofit entity which does not meet the definition of a community health center and cannot meet the conditions of award for operating grants specified in the bill (described below) can receive no more than two such operating grants. If such an entity is able at any point to meet these conditions and the definition of a center, it may receive additional operating grants.

Operating grants may not be made to entities which do not qualify as centers if these grants are made to extend planning and development activities begun under planning and development grants made to these entities. The Committee intends that in no case may more than two grants be made to an entity which does not qualify as a CHC nor shall the planning and development period for any project extend beyond two years.

The Committee is aware that HEW has recently been engaged in efforts to improve the collection by CHCs of third-party reimbursements for the services which they render. In general this effort by HEW is to be applauded since it will allow increased Federal grant support for new services or expanding target populations, and will prepare the centers for participation in national health insurance. However, the Committee wishes to make it clear that the centers are to serve people in need and not simply people for whom third party reimbursement is available. As a CHC succeeds in increasing third party reimbursement it is intended that existing Federal support be used to expand services or add new services, rather than being withdrawn. Further, it is the Committee's intent that centers be reimbursed for the full and reasonable cost of providing services regardless of the source of center funding, including Federal project grant funding. Any other determination of a lower reimbursement rate by any State or HEW would be directly contradictory to the Secretary's expressed goals of decreasing project dependence on direct Federal funding and directly contrary to the expressed intent of this Committee.

Medically underserved population

A medically underserved population is to be defined in regulations issued by the Secretary as the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Criteria or definitions for determining underservice or shortage used in other sections of the PHS Act or in implementing those sections are not necessarily the most appropriate for determining underservice for the purpose of this section, but such other efforts should be carefully reviewed before issuing different regulations under this section. It is also recognized that the population in virtually all cases will be specified in terms of a defined area since data from population groups is collected by area.

Catchment Area

The area served by a CHC (its catchment area) shall be reviewed periodically to insure the size of the area is such that the CHC's (or its satellites') services are available and accessible to the residents; to insure that the boundaries conform to the extent possible to existing political boundaries or boundaries established under Federal or State health or social programs, and to insure that the boundaries, to the extent possible, eliminate barriers (geographic, economic or transportation) to service.

Conditions for Approval of Applications

All applications for grants which include acquisition, expansion, modernization or renovation of facilities should contain a description of the site; plans and specifications; assurances as to title; and reasonable assurances that workers employed with respect to such work will be paid not less than prevailing wages for the locality as determined by the Secretary of Labor under the Davis-Bacon Act.

It is the intent of the Committee that the Secretary receive satisfactory assurance that grants for Community Health Centers will be used to supplement and, to the extent practical, increase the level of State, local, or other non-Federal funds (including third-party health insurance payments) available to the area—and not supplant such funds.

In addition, the Committee intends that the Secretary should determine, in consultation with the appropriate State and local health planning agencies, that the services to be provided by the Center will constitute an addition to or significant improvement in quality of services available in the area.

The same assurances with regard to reports, financial responsibility, arrangements under Title XIX of Social Security and third party reimbursement policy required for migrant health centers are also required before a CHC grant can be approved. For approval of planning and development or operating grants, the Secretary is required by the legislation to determine that the applicant has or intends to comply with the following additional conditions:

(1) A Center's services should be available and accessible and be provided to the individuals the Center services promptly and in a manner which overcomes geographical, cultural, linguistic, and economic barriers to care. They should be of high quality, assure continuity, and be provided in a manner which preserves human dignity.

(2) The applicant has established an ongoing quality assurance program, including utilization and peer review systems, as appropriate, in accordance with regulations prescribed by the Secretary. The confidentiality of patient records shall be maintained and provided the same protection against disclosure as provided other patient records in the State where the CHC is located.

(3) The applicant has used such accounting procedures as the Secretary may by regulations specify.

(4) The applicant has made or will make every reasonable effort to enter into a contractual arrangement with the State agency responsible for administering that State's Medicaid program, in order to assure payment to the CHC of all or a part of the applicant's costs in providing services to individuals who are eligible for medical assistance.

(5) The Center has prepared a schedule of fees or payments for the services it provides. These should be designed to cover a Center's reasonable costs of operation, including training. Another schedule should be prepared to allow for discounts in these fees and payments adjusted to the patient's ability to pay for services provided (but not when payments are collected from third parties). The schedules should be approved by the Secretary.

(6) The applicant has made or will continue to make every reasonable effort to collect reimbursement for services rendered to individuals who are entitled to insurance benefits under Medicare, to medical assistance under Medicaid, or to assistance for medical expenses under any other public assistance program or private health insurance program and from patients who are able to make payments in accordance with established fee schedules and applicable discounts. The applicant is also required to furnish such reports as the Secretary may require to determine compliance with this requirement.

(7) A governing board has been established by the applicant which is composed of individuals a majority of whom are being served by the project and who, as a group, represent the residents of the community served by the CHC or other entity. The board should meet at least once a month and should establish general policies for the applicant, including a schedule of hours during which services will be provided. This board should also be charged with the responsibility of approving the applicant's annual budget and its selection of a director.

(8) The applicant has developed an effective procedure for compiling and reporting to the Secretary statistics such as the costs of its operations, the patterns of utilization of its services, the availability, accessibility, and acceptability of its services. In addition, the applicant should develop, in accordance with regulations of the Secretary, an overall plan and budget that meets the requirements of Section 1861(z) of the Social Security Act. While these reporting requirements are mandated by legislation only for recipients of grants in medically underserved areas, it is not the Committee's intent or desire that the Secretary be prohibited from imposing similar requirements by regulation on all other grants recipients where the Secretary determines that this would be useful or necessary. The Committee, moreover, encourages an increase in this type of accountability by the recipients of grants and contracts.

(9) The boundaries of the area served by the applicant have been reviewed periodically to insure that the services provided by the applicant and its satellites are available and accessible and that barriers to services are, to the extent possible, eliminated, including identical patterns, its economic and social grouping, and transportation system.

(10) When a substantial proportion of the population served by the applicant is of limited English-speaking ability, the applicant has provided services in the language and cultural context most appropriate to bilingual and bicultural individuals. Under such circumstance, the applicant should have on its staff one or more individuals who are bilingual and whose responsibilities include assisting other members of the staff to bridge linguistic and cultural differences by making them aware of culture, health-related sensitivities of the population served by the applicant.

Technical Assistance

The Secretary is authorized to provide either directly, or by grant or contract, all necessary technical and other non-financial assistance to grantees to assist them in developing plans to become community health centers and complying with conditions for approval of initial operating grant applications. For such purposes, the Committee intends that the Secretary may use one percent of the amounts of CHC grants, appropriated for any fiscal year.

Appropriations Authorizations

The bill authorizes appropriations of \$220,000,000 for fiscal year 1976 (\$5,000,000 for planning and development grants and \$215,000,000 for operating grants) and \$240,000,000 for fiscal year 1977 (\$5,000,000 for planning and development grants and \$235,000,000 for operating grants).

TITLE VI—MISCELLANEOUS

DISEASES BORNE BY RODENTS

The proposed legislation would amend section 317 of the Public Health Service Act to expand the types of disease control programs conducted under this authority to include programs for the control of diseases borne by rodents. The Committee has recommended repeal of section 314(e) of the PHS Act (see Community Health Centers section), under which rodent control programs have been supported since 1969. The Committee feels very strongly that these effective programs should be continued. The legislation would increase the fiscal year 1976 authorization for section 317 by \$20 million for this purpose.

HOME HEALTH SERVICES

Background

Over the past few years, as hospital and nursing home costs have spiraled upward, much attention has been given to the search for alternative modes of care.

Home health care has been increasingly recognized as providing, in many instances, a less expensive and often more effective alternative to continuing hospital and nursing home care. In testimony before the Subcommittee on Health for the Elderly of the Senate Special Committee on Aging on July 12, 1973, Dr. Charles C. Edwards, Assistant Secretary for Health asserted: "There is no question . . . that the closer we could move health care to the people, the greater the effect it is going to have on the overall cost of health care. . . . We have to encourage the service that will push health care away from the hospital and closer to the home."

While no comprehensive analysis has been completed on the cost-effectiveness of home health care, several localized studies have pointed out that health care provided in the patient's home can be considerably less expensive than institutional care. These studies have generally focused on the savings realized by early transfer of patients from hospitals to home care programs. For example, a study by the Rochester, New York Home Care Association showed an estimated reduction of 13,713 patient days and a savings of \$1,055,000 in calendar year 1970 and an estimated reduction of 12,579 days and a savings of \$1,068,000

in calendar year 1971 as a result of early release of patients from hospitals to home health programs.

Another study, by the Denver Department of Health and Hospitals on the results of its Early Hospital Discharge Program showed that savings of \$515,729 in hospital costs for Medicare patients were achieved in 1970 as a result of early discharge of 292 patients from hospitals to home care programs.

A 1970 report, prepared by the Health Services Research Center, Kaiser Foundation Hospitals in Portland, Oregon, compared the costs of care provided to a select population of over 100,000 persons under age 65 in a comprehensive, prepaid group practice plan. The study revealed that comparative daily costs for this population was \$5.26 for home health care, \$39.08 for an extended care facility and \$72.62 for hospitalization. While the age and health status of the population studied as well as the care system in which the services were provided preclude general application of these cost comparisons, they are illustrative of the potential of home health services.

A report prepared for the Senate Special Committee on Aging in July 1973 ("Home Health Services in the United States: A Working Paper on Current Status") summarized the benefits of effective home health care programs as follows:

1. Patients prefer care that can be provided in the normalcy of their home environment.
2. Home-bound people can be taught to live in a relatively independent status.
3. The need for initial admission or readmission to in-patient institutions can be diminished.
4. For the necessary institutional admission, unnecessary days can be eliminated through early discharge to home care.
5. Capital construction costs for inpatient facilities can be reduced.
6. The efficiency of the practicing physician can be increased by expanding the team approach. The physician can care for a greater number of patients through a home care program because he does not have to assemble and coordinate individually the services needed for his patients in their home settings.
7. Home care staff can readily interpret medical orders, explain treatment regimes, and offer reassurance and support.
8. Home care staff can identify day-to-day problems and thus help to reduce the possibility of emergency situations arising.

In spite of the mounting evidence that home health care would be both a cost effective and humane approach to providing needed care, the number of agencies in the Nation providing such care is decreasing, and the numbers of persons receiving care in institutional settings is increasing. When Medicare benefits went into effect on July 1, 1967, there were 1474 agencies certified by the Social Security Administration to provide home health benefits. In 1970, this number had increased to a peak of 2350. Currently, there are 2222 certified home agencies participating in the Medicare and Medicaid programs.

In part, the large increase in home health agencies in the early years of Medicare was partially due to the availability of a new source of reimbursements which encouraged many communities to create home health care providers. The increase also resulted from the availability of Federal formula grants in 1966 and 1967 which provided almost

\$16 million to State health departments to foster the creation or expansion of public and private non-profit home health agencies. The Partnership for Health amendments in 1967 (P.L. 89-749) integrated the home health grant program into the 314(d) formula grant. Unfortunately, most states decided not to direct any portion of their noncategorical funds into home health services.

While the enactment of the Medicare and Medicaid legislation gave impetus to the establishment of home health agencies, reimbursement for home health services available under these programs does not provide an adequate mechanism for creating resources. Payments from these two programs are made only to agencies which have been certified as meeting the standards for participation established by the programs and only after covered services have been rendered to the patients. Medicare and Medicaid funds, therefore, are not available to assist in initiating services by a new agency and only moderately useful in assisting in the expansion of services.

Proposed legislation

The Committee believes that it is essential to stimulate the growth and expansion of home health services and to determine their cost effectiveness and efficiency through a special demonstration assistance program. The proposed legislation would authorize demonstration grants for (1) the initial costs of establishing and operating (including the costs of compensating professional and paraprofessional personnel) of home health services agencies in areas in which such services are not now available; and (2) the expansion of services provided by existing agencies. The agencies assisted and the services provided would be required to meet the Medicare definitions of a home health agency (section 1861(o)) and home health services (section 1861(m)). These requirements will assure that agencies assisted under the bill will be eligible to receive Medicare (and Medicaid) payments for services rendered to beneficiaries of those programs.

The legislation would require the Secretary of HEW, in awarding grants for such purposes, to consider the relative needs of the States for home health services and give preference to areas within States in which a high percentage of the population proposed to be served is composed of individuals who are elderly, medically indigent, or both. Approximately one-half of the counties in the United States have no home health services, with the rural counties particularly underserved. In addition, over one-half of the Medicare certified home health agencies consist of one or two nurse staffs, and provide only one service in addition to skilled nursing care.

For these purposes, the legislation would authorize appropriations of \$8 million for fiscal year 1976.

In order to maintain and improve the quality of care provided by home health agencies, the bill would also authorize demonstration grants for training professional and paraprofessional personnel in the provision of home health care. For these purposes the legislation would authorize \$2 million for fiscal year 1976. Since lack of managerial capability is often cited as an important factor in the failure of home health agencies to succeed, the Committee feels that some emphasis should be given to the training of personnel to organize and manage efficient home health care programs.

The Committee notes that both Medicare and Medicaid have been criticized by observers of our health care delivery system for not providing greater encouragement for the use of home health services as a lower cost alternative to hospital and nursing home care. Most recently, a comprehensive report of the General Accounting Office concluded that "the Medicare and Medicaid home health programs are not working as effective alternatives to institutional care." Some of the difficulties in Medicare, the Report stated, are due to statutory limitations, other are related to the administration of the program by the Social Security Administration, and still others are related to securing the support and cooperation of the providers of medical services, particularly physicians. A major problem for the home health agencies and for the Medicare beneficiaries has been the denial of payments by the Social Security Administration after services were rendered on the basis that the condition of the patient did not justify home health services as defined in the Medicare statute or that the services themselves were not "covered" under the law. These determinations, however, were based on budgetary considerations which led the Social Security Administration to develop and apply increasingly restrictive interpretations of the language in the law.

In contrast, the GAO Report concluded that in Medicaid the potential inherent in home health care has not been fully realized because the Department of HEW has not provided the States with adequate guidance on (1) the objectives of the program, (2) the scope of allowable home health care services, or (3) the establishment of payment rates on a reasonable cost related basis. As a result, States have designed and installed home health care programs widely varying in amount, duration and scope of benefits with many Medicaid programs adopting the highly restrictive Medicare model. At the same time, the GAO found, the rates paid to home health agencies in a number of States reimburse those agencies at less than their cost of providing services.

The Committee is concerned that its efforts to stimulate the development of home health agencies will be frustrated if the two major Federal programs which provide payments for home health services continue to interpose obstacles to the rational development of these services either through overly aggressive and restrictive administrative controls such as have been exercised in Medicare, or the failure, as evidenced in the Medicaid program, to provide sufficient administrative guidance and program oversight to the States.

The Committee, therefore, urges the Secretary of HEW to act positively on the GAO recommendations and take steps to stimulate the use of an adequate payment for home health services provided to Medicare and Medicaid beneficiaries.

COMMITTEE ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

Background

In 1971 the Senate's Special Committee on Aging issued a report on *Mental Health Care of the Elderly; Shortcomings in Public Policy*. This report, the result of a thorough review and analysis of the many issues involved in the mental health care needs of the elderly in the Nation, recommended legislation which would establish a Commission on the Mental Health and Illness of the Elderly. This report and

its recommendations received the approval and support of the Group for the Advancement of Psychiatry, the American Psychiatric Association, and the American Psychological Association.

The 1971 report recommended the creation of a commission because "public policy in the mental health care of the aged is confused, riddled with contradictions and shortsighted limitations and is in need of intensive scrutiny geared to immediate and long-term action." The Committee believes that neither the magnitude of the mental health care problems of the elderly nor the need for their intensive scrutiny has diminished in the four years which have elapsed since the publication of the report; indeed there are indications that they have become more acute and compelling. The American Psychological Association has stated that there are three million elderly who require mental health services, but scarcely 20 percent of this number have their needs met through existing resources. Medicare has been of little assistance, and while mental health services are available to the aged in approximately 40 State Medicaid programs, many of the nation's elderly fail to meet the eligibility criteria required for these programs' services.

Under circumstances such as these, the Committee believes that there exists a pressing need for a committee which could develop a national policy for the maintenance and improvement of the mental health of the nation's elderly population. Such a committee could assess the mental health care needs of the elderly and, in so doing, examine available resources, including mental health facilities, manpower, research, and training, to determine their adequacy for meeting the determined and defined needs of the elderly. It is anticipated that such an assessment would assist the Committee in making recommendations for solving problems with potentially great adverse impact on the mental health of the elderly.

One such problem which particularly concerns the Committee at the present time is a growing tendency for the States to transfer patients from State hospitals into nursing homes, boarding homes, and other smaller community-based facilities. According to data developed by the Committee, the number of elderly in State institutions dropped 40 percent between 1969 and 1973. In 1969 there were 133,264 aged in State mental institutions, but only 81,912 by the end of 1973. This rapid transfer has come to the Committee's attention because of evidence which suggests a dangerous lack of screening procedures to determine proper candidates for discharge and transfer as well as an absence of follow-up activities to determine if such individuals have been properly placed in their new facilities. Moreover, it has been demonstrated that the nursing homes, boarding homes, or shelter facilities to which these elderly have been transferred are not prepared to provide the kind of care required by these patients: frequently, psychiatric services are not offered and seldom do these institutions have established programs for the rehabilitation of patients. It is problems such as these which the committee could address and examine as well as offer recommendations for correction and solution.

Proposed Legislation

The proposed legislation requires the Secretary of HEW to establish a temporary Committee on Mental Health and Illness of the Elderly. The Committee would undertake a study and make recommendations concerning (1) the future needs for mental health facili-

ties, manpower, research, and training to meet the mental health care needs of elderly persons; (2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and (3) proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly. The findings of this Committee would be submitted to the House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Public Welfare within one year of the enactment of this legislation.

The committee would be composed of nine members appointed by the Secretary. Among these nine, there should be included at least one member from each of the fields of psychology, psychiatry, social science, social work, and nursing. Each member should be exceptionally qualified by virtue of training, experience, or attainments to assist in carrying out the functions and responsibilities of the committee.

COMMISSION FOR THE CONTROL OF EPILEPSY

Background

Current estimates are that 1 to 2 percent of all Americans are affected by epilepsy, making it a health problem of national concern. Children are especially subject to this disorder. Approximately 667,000 elementary school children and 300,000 secondary school children have seizure disorders which, if left untreated create learning barriers, deter social development and prevent their victims from achieving self-sufficiency.

The problems which confront the epileptic child, however, are compounded by maturity. Unemployment rates among epileptics are now 6 times higher than the national average. Other problems such as obtaining a driver's license, or life, health, accident and/or automobile insurance are common occurrences for people suffering from epilepsy.

The Committee finds that there is a need for more basic research not only into the causes of epilepsy, but also into treatment and prevention. One of the most difficult barriers to adequate treatment has been and continues to be public misunderstanding about this disorder which with proper treatment can be controlled. In addition, there is a greater need for social and rehabilitation programs ranging from classroom materials to training and rehabilitation of epileptics, as well as sources of public health information and educational materials. It is the Committee's belief that because of the nature of this neurological disorder and its social, medical and economic consequences, there exists a need for development of a comprehensive understanding of the current state of the art in medical treatment as well as coordination of the various programs and services directed toward epilepsy. There are now over 100 voluntary organizations involved in some way with the problems of people with epilepsy as well as some 30 agencies of the Federal government.

It is the Committee's belief that by development of an overall plan detailing the roles of Federal and local governments, as well as private agencies, better coordination and a concentrated focus on this major health problem will be achieved, and further advancement in controlling epilepsy will be forthcoming.

Proposed Legislation

The Committee finds that the appointment of a National Commission to develop a comprehensive plan with recommendations for any appropriate legislation will serve to focus the attention of the numerous agencies involved in working with epilepsy as well as provide meaningful data on current needs and programs. The legislation, therefore, requires the Secretary of HEW to establish a temporary Commission for the Control of Epilepsy and Its Consequences which would (1) make a comprehensive study of the state of the art of medical and social management of the epilepsies; (2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with epilepsy; and (3) develop a comprehensive national plan for the control of epilepsy and its consequences based on the most thorough, complete, and accurate data and information available on the disorder. The findings and conclusions of the Commission, together with recommendations for legislation and appropriations, would be submitted to the President and to the House Committee on Interstate and Foreign Commerce, and the Senate Committee on Labor and Public Welfare within one year of the enactment of this legislation.

The Commission would be composed of nine members appointed by the Secretary. Members should be individuals who, by reason of experience or training in the medical, social, or educational aspects of epilepsy, are especially qualified to serve on the Commission.

COMMISSION FOR THE CONTROL OF HUNTINGTON'S DISEASE

Background

Huntington's chorea is a chronic, degenerative disorder of the nervous system. The disease is genetically inherited, and the children of an affected parent have a 50 percent chance of developing the disease. Because the clinical symptoms or manifestation of Huntington's chorea usually do not appear before the age of 30 or 40, many people who develop the disease have become parents subjecting their children to the possibility of Huntington's disease as well. If an effective means were developed to detect the disease earlier, it would then be possible to offer genetic counseling to individuals potentially carrying the defective gene.

Presently the National Institute of Neurological Disease and Stroke and the Division of Research Resources of the National Institute of Health, the National Institute of Mental Health, the National Institute of Arthritis, Metabolism, and Digestive Diseases, and the National Institute of Child Health and Human Development each have some type of program to study Huntington's chorea. However, there is no overall, unified plan to combat this disease.

It is the Committee's belief that there exists a need for the development of a comprehensive understanding of current methods to treat and manage Huntington's disease. In addition, a comprehensive plan detailing the roles of Federal and local governments, as well as private agencies, would provide better coordination of the various programs and services directed toward this disease. It is anticipated

that with such a concentrated focus on this health problem, advances in treatment and curative techniques and methods will ultimately be achieved.

Proposed Legislation

The Committee finds that the appointment of a National Commission to develop a comprehensive plan with recommendations for any appropriate legislation will serve to focus attention on the numerous agencies involved in working with Huntington's disease as well as provide meaningful data on current needs and programs. The legislation, therefore, requires the Secretary of HEW to establish a temporary Commission for the Control of Huntington's Disease and Its Consequences which would (1) make a comprehensive study of the state of the art of medical and social management of Huntington's disease; (2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with Huntington's disease; and (3) develop a comprehensive national plan for the control of Huntington's disease and its consequences based on the most thorough, complete, and accurate data and information available on the disorder. The findings and conclusions of the Commission, together with recommendations for legislation and appropriations would be submitted to the President and to the House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Public Welfare within one year of the enactment of this legislation.

The Commission would be composed of nine members appointed by the Secretary. Members should be individuals who, by reason of experience or training in the medical, social, or educational aspects of Huntington's disease, are especially qualified to serve on the Commission. The legislation further specifies that among these members there should be included consumers of health services.

HEMOPHILIA PROGRAMS

Background

Hemophilia is a genetically transmitted blood disorder which prevents normal blood coagulation and results in excessive and sometimes fatal bleeding, either internally or externally. The typical hemophiliac is usually a male who is born with the disease and, in the absence of treatment, suffers its effects throughout his lifetime.

Hemophiliacs fall into three major categories depending on the severity of the disease. First, the severe hemophiliac who is subject to spontaneous hemorrhaging into soft tissues, bones, joints, and muscle, and who bleeds after any type of trauma or minor surgery. The system of such an individual lacks virtually all ability to clot. Second, the moderate hemophiliac who rarely hemorrhages spontaneously but may experience significant bleeding after minor trauma. This individual may go undiagnosed for a long period of time. Third, the mild hemophiliac who is generally detected only after severe trauma or surgery during which bleeding cannot be easily controlled but in all other circumstances may be said to live a normal life.

Hemophilia is an extremely painful disease. The bleeding is usually spontaneous and the episodes are unpredictable. With repeated bleed-

ing into joints, the hemophiliac becomes immobilized by his own blood. Even a simple tooth extraction can present a major problem requiring many transfusions and, in some instances, hospitalization.

Of the approximately 100,000 hemophiliacs in the United States today, it is estimated by the National Heart and Lung Institute that about 25,499 of these individuals are under treatment for severe or moderate forms of the disease. Eighty-eight and three-tenths percent of all hemophiliacs are under 25 years old compared to 47.5% of U.S. males under the age of 25.

Hemophiliacs are unique among chronic disease victims because they are not born with disabilities and can lead relatively normal lives if financial conditions permit them to take advantage of newly developed forms of therapy. Without this ongoing treatment, severe and moderate hemophiliacs suffer tragic consequences throughout their lifetimes and become an unnecessary burden to themselves, their families, and the whole society. For example, among patients under 16 years of age, 65% report that hemophilia has caused poor attendance in school and among hemophiliacs not in school at all, nearly one-third cited poor health as the reason. Over 40% of the patients over 16 years of age are not employed and more than half of these cited poor health as the primary reason. In addition, of the hemophiliacs who are employed, more than one-third indicated that their disease influenced the type of employment they were able to obtain.

The employment of a hemophiliac's parents seems also to be strongly influenced by the disease. 11% of all fathers selected their present jobs because of the child's illness. 20% of fathers have second jobs in order to meet treatment costs, and over one-third of victims' mothers who work do so to help meet costs.

In the mid-1800's, it was found that bleeding in a hemophiliac could be controlled to some extent through the transfusion of whole blood into a patient. This was the beginning of what is known as "replacement therapy." But it was not a very satisfactory or efficient means of treatment. In the last two decades, medical research made great advances in discovering the missing factor which prevented blood coagulation. In 1964 it was demonstrated that this factor—primarily an element known as Factor VIII—could be removed from human plasma by a process known as cryoprecipitation. By replacement of this missing factor, bleeding is rapidly checked with prompt cessation of pain. As a result of this new treatment technique, clinicians, no longer forced to focus on acute crises produced by bleeding, have made major strides in developing new treatment modes for this disease. The concepts of home care, of self-infusion, and the comprehensive care approach to hemophilia have all been developed and improved upon within the last 10 years. It is now possible for patients to self-administer treatment immediately following the onset of bleeding or on a prophylactic basis thereby obviating the debilitating effects of delayed treatment and the need to be brought to a treatment facility which is both time-consuming and more costly.

Unfortunately, only 10% of hemophiliacs are on any home care. Nor do the vast majority of hemophiliacs have the necessary resources to receive the benefit of this and other advanced treatment techniques. This is due to several reasons.

First, in the treatment of a disease, the factor of a relatively high volume of patients encourages the development and maintenance

of professional and technical resources for treating the disease. With a large number of patients available, medical and technical staff can use their skills frequently enough to develop and improve proficiency, and the development of specialized support services becomes more feasible. Yet physicians in the United States have only relatively minor involvement in hemophilia treatment. According to the National Heart and Lung Institute, during 1970 and 1971, over 95% of all physicians treated fewer than 10 hemophiliacs and two-thirds of these were not in hospital based practices. In fact, during that time period, 60% of all physicians treated only one hemophiliac and 34.5% treated only two or three patients. Thus, this lack of exposure by the medical community accounts for the provision of less than optimal care for hemophiliacs.

Second, while most physicians prefer to treat their hemophiliac patients in a hospital setting with its attendant access to medical-surgical inpatient facilities and blood banking laboratories, there are relatively few clinical facilities which offer comprehensive care for hemophiliacs. According to testimony presented to the Senate Committee on Labor and Public Welfare, there are only a small number of comprehensive care clinics in the nation. The National Hemophilia Foundation estimates that there are only 67 such clinics in 27 States and the District of Columbia. Not all of these are truly comprehensive in the sense that they are staffed with hematologists, orthopedists, dentists, social workers, psychiatrists, physical therapists, and vocational and genetic guidance counselors. In addition, only 6 clinics (in Los Angeles; New York City; Philadelphia; Rochester, Minnesota; Boston; and Chapel Hill, North Carolina) have teaching capabilities in this specialty so that physicians in those areas can learn the latest techniques. In addition, 8 States have no known facilities at all and 15 States have only emergency facilities. Thus, centers capable of making accurate diagnoses, prescribing and delivering optimal care, and making patients aware of all available resources in the community do not exist in adequate numbers leaving thousands of hemophilia patients without the best available services.

Third, replacement therapy challenges our blood banking resources and technology. In 1971, approximately 9.5 million units of blood were collected in this country by more than 5,000 facilities. As stated above, it was only recently recognized that by fractionation or separation of blood a single unit can supply the need of many individuals. This means that a unit of blood is fragmented and its parts distributed and used according to varying specific needs. Hemophiliacs, generally, need only a small plasma portion called cryoprecipitate. A leukemic is able to utilize the platelets derived from the same unit. Another patient, perhaps hospitalized with a bleeding ulcer, might use the red cells. But our nation's poorly coordinated blood services result in the separation or fractionation of only 30% of the blood collected. This is in contrast to Australia, for example, where all collected blood is broken down into 15 different components. For all hemophiliacs to receive the finest prophylactic replacement therapy with the most sophisticated anti-hemophiliac blood concentrates, it has been estimated by the National Heart and Lung Institute that as much as 13.3 million units of whole blood would be required. And, although these most refined treatment methods are not necessarily appropriate for all hemophiliacs, better treatment techniques than are currently provided could result

in a critical shortage of blood. Our nation can only come to grips with this problem and the problem of less than adequate treatment for hemophiliacs if more whole blood can be separated and/or fractionated into its component parts. If this result is achieved we might well find that our present volume of collected blood could come closer to meeting our national needs.

Finally, and of utmost concern to the Committee, hemophilia poses severe financial problems for its victims and their families. Replacement material, whether it is plasma, cryoprecipitate, or dry Factor VIII or Factor IX concentrate, is extremely costly. Studies conducted by the National Heart and Lung Institute estimate that with current treatment modalities (which are far less than adequate for hemophiliacs), the average family spent \$2400 per year for blood products and \$1000 for related care. Some families reported spending up to \$65,000 for care. At the Hemophiliac Center of Rochester and Monroe County in New York (which is one of the better comprehensive care centers in the nation) the average costs for blood products alone on a per patient basis was \$4,890 in 1973. The father of a young man on self-infused prophylactic therapy (using 2 vials of concentrate per day) spends \$22,000 per year for the blood products alone. And the parents of another young man accumulated \$31,000 in medical bills over the last two years due to the severity of his hemophilia. On the average it was testified that a sound regimen of replacement therapy would cost between \$5,000 to \$6,000 per year per patient.

Proposed legislation

The proposed legislation would amend the Public Health Service Act by adding a new part D to Title XI of this Act to provide Federal assistance for projects (1) to establish comprehensive hemophilia diagnostic and treatment centers, and (2) to develop and expand, within existing facilities, blood-separation centers.

Treatment centers

The legislation would authorize the Secretary of HEW to make grants to and enter into contracts with public and nonprofit private entities for projects to establish comprehensive hemophilia diagnostic and treatment centers. While there are presently 67 existing centers in 27 States, there is a continuing need for such facilities in areas which have no or only limited diagnostic and treatment facilities. The centers contemplated under this section would be required to assure access to services for all individuals who reside within the geographic area served by the center and who are suffering from hemophilia. The centers should also serve as a resource for providers of health care who are in outlying areas and who do not have access to the services offered by a comprehensive care center. This latter provision is extremely important in view of the evidence that so many physicians who treat hemophiliacs have less than two or three patients and thus can benefit from the knowledge and skills available at a comprehensive facility. In addition to these requirements, centers should emphasize outpatient care, provide (in addition to necessary medical services) social and vocational counseling, and serve as training centers for professional and paraprofessional personnel in hemophilia research, diagnosis, and treatment.

The legislation would require the Secretary, in considering applications for projects to establish hemophilia diagnostic and treatment centers, to (1) take into account the number of persons to be served by such centers and the extent to which rapid and effective use will be made of the funds, and (2) give priority to projects for centers which will operate in areas which he determines have the greatest number of persons in need of the services to be provided by the center.

For establishing treatment centers, the legislation would authorize \$3 million for fiscal year 1976 and \$4 million for fiscal 1977.

Blood separation centers

It is the purpose of this section to provide assistance for the development or expansion of facilities which will separate components from whole blood so that more efficient use can be made of this precious raw material. With the enactment of this legislation and with the greater use by physicians of blood components (such as red blood cells, platelets, white blood cells, AHF-rich fresh frozen plasma, and cryoprecipitate) there will be a substantially larger demand for these products. In addition, it is not the common practice for blood banking facilities to maximize the use of whole blood through separation techniques. The Committee therefore believes that the financial assistance contemplated in this section will serve to encourage the blood banking community to make components more readily available.

This section also provides that the Secretary may make grants to blood banking facilities which are already engaged in the production of blood fractions. These components require a highly complex technology for their manufacture and the equipment and facilities necessary for their production is extremely expensive. There are currently eleven private companies which are licensed by the FDA to produce blood fractions. Such fractions as defined in the bill include AHF concentrate, normal serum albumin, plasma protein fraction, fibrinogen, prothrombin complex, immune serum globulin, and hyperimmune globulins. It is the Committee's understanding based on estimates supplied to it that it might cost in excess of \$5 million to build, equip, and staff a new fractionation facility and it was therefore felt that existing facilities should be developed to a greater capacity. However, in view of the fact that there are several non-profit facilities which are equipped to engage in the fractionation process, there should be available some Federal support should there be a finding that there is a shortage of blood fractions available to meet the medical treatment demands for hemophilia. The expansion of these facilities in the case of a shortage, together with grants for increased separation of whole blood, should go a long way toward meeting the treatment needs of hemophiliacs and will also serve to assure optimal utilization of blood for all those who require blood products.

For grants for these purposes, the legislation would authorize \$4 million for fiscal year 1976 and \$5 million for fiscal year 1977.

TITLE VIII—EXTENSION OF CURRENT AUTHORITIES THROUGH FISCAL YEAR 1975

Because of the President's veto of H.R. 14214, there is presently no authorization of appropriations for health revenue sharing, family planning, community mental health centers, migrant health and com-

munity health centers. These programs must rely upon continuing resolutions in order to receive continued funding.

In view of the fact that the proposed changes in existing law would require the promulgation of new regulations and impose new requirements upon grant recipients, the Committee has chosen to extend, at 1974 authorization levels, provisions of existing law with respect to these five programs. This determination by the Committee will serve two purposes: it will allow potential recipients of Federal funds sufficient lead-time to comply with new requirements and, hopefully, it will remove the President's objections, for fiscal reasons, to the provisions of this legislation.

SECTION-BY-SECTION ANALYSIS OF H.R. 4925, THE HEALTH REVENUE SHARING AND HEALTH SERVICES ACT OF 1975

Section 1.—Provides that the Act may be cited as the Health Revenue Sharing and Health Services Act of 1975, and states that the amendments made by Titles I through VI of this Act shall take effect July 1, 1975, except as may otherwise be specifically provided. Further states that these amendments apply to relevant sections of the Public Health Service Act (PHS Act) as amended by Title VII of this legislation.

TITLE I—HEALTH REVENUE SHARING

Section 101.—Provides that Title I may be cited as the “Special Health Revenue Sharing Act of 1975”.

Section 102.—Amends Section 314(d) of the PHS Act to read as follows, effective with fiscal years beginning after June 30, 1975:

COMPREHENSIVE PUBLIC HEALTH SERVICES

New Section 314(d)(1).—Provides that from allotments made pursuant to paragraph (4) below, the Secretary shall make grants to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services.

New Section 314(d)(2).—Provides that no grant may be made under paragraph (1) to a State health or mental health authority unless an application for the grant has been submitted to and approved by the Secretary. Further provides that this application should be submitted in such form and manner and should contain such information as the Secretary may require. The application should, in addition, contain or be supported by assurances satisfactory to the Secretary that—

(A) The comprehensive public health services provided within the State will be provided in accordance with the State plan prepared in accordance with Section 1524(c)(2) of the PHS Act or the State plan approved under Section 314(a), whichever is applicable;

(B) Funds received under paragraph (1) will be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided and will not be used to supplant such non-Federal funds;

(C) The State health authority, and, with respect to mental health activities, the State mental health authority will (i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds received under this authority; (ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national health program reporting system and by such

categories as the Secretary may prescribe) a description of the comprehensive public health services provided in the State and its communities in the fiscal year for which the grant is made and the amount of Federal, State and local government funds obligated or expended in such fiscal year for the provision of each such category of services; and (iii) make such reports as the Secretary may reasonably require and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports.

(D) The State mental health authority will, in addition: (i) establish and carry out a plan which (I) is designed to eliminate inappropriate placement of persons with mental health problems in institutions, in order to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate; and (II) includes fair and equitable arrangements, as determined by the Secretary, to protect the interests of employees affected by actions taken pursuant to such plan, including arrangements designed to preserve employee rights and benefits and to provide appropriate training and retraining of such employees who are employed by the State or any of its political subdivisions; (ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) within the State; and (iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers or other appropriate entities of residents of the State who are being considered for inpatient care in a mental health facility to determine if such care is necessary, and (II) provision of follow-up care by community mental health centers or other appropriate entities for residents of the State who have been discharged from mental health facilities.

New Section 314(d) (3).—Requires the Secretary to review annually the activities undertaken by each State with an approved application to determine if the State complied with the assurances provided with the application. Further specifies that the Secretary may not approve an application submitted by a State if he determines that the State did not comply with assurances provided with a prior application and cannot be assured that the State will comply with the assurances provided with the application under consideration.

New Section 314(d) (4).—Requires the Secretary in each fiscal year, in accordance with regulations, to allot sums appropriated for that year among the States on the basis of population and financial need. Specifies that the populations of the States are to be determined on the basis of the latest figures available from the Department of Commerce.

New Section 314(d) (5).—Requires the Secretary to determine the amount of any grant made under paragraph (1), and specifies that the amount of grants made in any fiscal year to the public and mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Provides that payments under such grant may be made in advance or by way

of reimbursement, and at such intervals and on such conditions as the Secretary finds necessary.

New Section 314(d)(6).—Specifies that in any fiscal year not less than fifteen percent of a State's allotment be made available to the State's mental health authority, if separate from the State health authority, for the provision of mental health services under the State plan and not less than 70 percent of the amount of a State's allotment which is made available for grants to the mental health authority, and 70 percent of the remainder of the State's allotment, be made available only for the provision of services in the communities of the State.

New Section 314(d)(7).—Authorizes, for the purposes of making grants under this section, appropriations of \$100 million for fiscal year 1976, and \$110 million for fiscal year 1977. Authorizes additional appropriations of \$15 million for fiscal year 1976 and \$15 million for fiscal year 1977 for the purposes of making grants to State health authorities for establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension. The Committee intends that accountability for the expenditure of these funds be accomplished through the same audit procedures and uniform national health program reporting system mandated for other funds awarded under this section.

TITLE II—FAMILY PLANNING PROGRAMS

Section 201—provides that this title may be cited as the "Family Planning and Population Research Act of 1974."

Section 202(a)—amends section 1001(c) of the PHS Act to authorize appropriations for project grants and contracts for family planning services of \$110 million for fiscal 1976 and \$140 million for fiscal 1977.

These and subsequent figures are less than indicated as needed in the 5 year plan for family planning services required by the original Family Planning Act of 1970. The Committee feels that this plan was well drawn and that the figures which are included in it are reasonable to the nation's needs and hopes that full appropriations will be made for these various activities.

Section 202(b)—amends section 1003(b) of the PHS Act which provides for training grants and contracts for family planning by authorizing appropriations of \$4 million for fiscal year 1975 and \$5 million for fiscal year 1976.

Section 202(c)—amends section 1004 of the PHS Act which provides for research grants and contracts for family planning with a new text which provides as follows:

RESEARCH

New section 1004(a)—authorizes the Secretary to conduct and make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.

This provision is essentially identical to existing section 1004(a) except that it authorizes the Secretary to engage in direct research activities and contains technical revisions of the existing section.

New section 1004(b)—authorizes appropriations for such research activities of \$55 million for fiscal 1976 and \$60 million for fiscal 1977. Requires that no funds appropriated under any other provision of the PHS Act (other than this subsection) are to be used to conduct or support the research for which authority is given in section 1004(a).

The Committee has long taken the position that, when a specific authority is provided to the Secretary for the conduct of an activity, the Secretary should use that authority rather than his more general standing authorities. Family planning research activities since 1970 have, despite the existence of section 1004(a), been conducted under the authority of section 301 of the PHS Act. This provision is designed to prevent the use of section 301 for these activities. The authorizations chosen reflect the amounts presently being appropriated under section 1004(a) for the few operational research activities for which it has been used, the amounts presently being appropriated under section 301 for family planning research, and additional amounts to aid in appropriate growth.

Section 202(d)—amends section 1005(b) of the PHS Act which provides authorizations of appropriations for grants for informational and educational materials by authorizing appropriations of \$2 million for fiscal 1976 and \$2.5 million for fiscal 1977.

Section 203(a)—amends title X of the PHS Act by inserting at its end a new section with the following provisions:

PLANS AND REPORTS

New section 1009(a)—requires the Secretary, within four months after the end of each fiscal year, to make a report to the Congress and set forth a plan to be carried out over the next five fiscal years to accomplish the following objectives:

- (1) extension of family planning services to all persons desiring such services;
- (2) family planning and population research programs;
- (3) training of necessary manpower for the programs authorized by title X of the PHS Act and other Federal laws for which the Secretary has responsibility; and
- (4) carrying out the other purposes set forth in title X and the

Family Planning Services and Population Research Act of 1970.

This new section has essentially the same provisions as the existing requirements of the Family Planning Services and Population Research Act of 1970 for the preparation and submission to the Congress of a Five Year Plan for family planning services. The original requirement of the 1970 Act was a one time requirement for the preparation of a plan. Since the Committee has now decided that it would be more appropriate to keep the Five Year Plan up to date on an annual basis so that it can continue to be used as a guide for the program, these existing provisions of the 1970 Act have been made a part of the permanent provisions of the PHS Act.

New section 1009(b)—requires that the Five Year Plan must, at a minimum, indicate on a phased basis:

- (1) the number of individuals to be served by the family planning programs under title X and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be

developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet the purposes of title X and other Federal laws for which the Secretary has responsibility and which pertain to family planning programs; and

(3) the steps to be taken to maintain a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department are to be based.

This provision is essentially identical to one contained in the existing requirement for a Five Year Plan. It should be emphasized that the Committee intends the requirement for a systematic reporting system to be one which will report on services provided under all authorities for which the Secretary is responsible for family planning including those provided under title IV-A and, eventually, title XX of the Social Security Act. It is further anticipated that the reporting system will function nationwide on at least an annual basis to provide to the Secretary, the public and the Congress systematic and complete data on the number, costs, and effectiveness of family planning services being provided by the Department, either directly or indirectly.

New section 1009(c)—requires the report submitted under section 1009(a) to:

(1) compare results achieved during the preceding fiscal year with the objectives established for that year under the plan contained in the report;

(2) indicate steps being taken to achieve the objectives during the remaining fiscal years of the plan contained in such report and any revisions necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan contained in the report.

Section 203(b)—repeals section 5 of the Family Planning Services and Population Research Act of 1970. Section 5 contains the requirement for a Five Year Plan and will no longer be needed upon enactment of the new Five Year Plan requirements in the PHS Act.

Section 204(a)—amends Section 1001(a) of the PHS Act to provide that family planning projects shall include natural family planning methods.

Section 204(b)—amends section 1001(b) of the PHS Act to preserve the right of local and regional entities to apply for and receive grants and contracts for family planning projects (in lieu of State consolidation grants), and requires the Secretary to issue regulations to this effect.

Section 204(c)—amends section 1006(a) of the PHS Act to require that the Federal share of the project grants awarded after fiscal year 1975 to be 90 percent of project costs (as determined by regulations) unless the award is for a continuing grant which is already less than 90 percent, in which case the Federal share cannot be further reduced.

Section 204(d)—amends section 1006(c) of the PHS Act (which requires the Secretary to define "low income family") by adding the requirement that the definition be such as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title.

This amendment is designed to insure that medically indigent families are never charged for family planning services for which they cannot pay. This amendment will thus require the Secretary to use a definition of "low income family" which is geared specifically to the burden of paying for family planning services as it is born by medically indigent families, rather than a definition which is simply borrowed from some other source and irrelevant to the costs of family planning services.

TITLE III—COMMUNITY MENTAL HEALTH CENTERS

Section 301—provides that this title may be cited as the "Community Mental Health Centers Amendments of 1975".

Section 302(a)—makes Congressional findings that:

(1) community mental health care is the most effective and humane form of care for a majority of mentally ill individuals;

(2) the federally funded community mental health centers (CMHCs) have had a major impact on the improvement of mental health care by:

(A) fostering coordination and cooperation between various agencies responsible for mental health care which in turn has resulted in a decrease in overlapping services and more efficient utilization of available resources;

(B) bringing comprehensive community mental health care to all in need within a specific geographic area regardless of ability to pay; and

(C) developing a system of care which insures continuity of care for all patients; and

thus are a national resource to which all Americans should enjoy access; and

(3) there is currently a shortage and maldistribution of quality community mental health care resources in the United States.

Section 302(b)—makes a Congressional declaration that Federal funds should continue to be made available for initiating new and continuing existing community mental health centers and initiating new services within existing centers, and for the monitoring of the performances of all Federally funded centers to insure their responsiveness to community needs and national goals relating to community mental health care.

Section 303—amends the Community Mental Health Centers Act with the following new text. The Community Mental Health Centers Act is title II of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963 (PL 88-164). The new title is to begin with the following headings:

TITLE II—COMMUNITY MENTAL HEALTH CENTERS

Part A—Planning and Operations Assistance

REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS

New Section 201(a)—provides that for the purposes of this title (other than part B, which provides for financial distress grants to

existing and new CMHCs) the term "Community Mental Health Center" means a legal entity—

(1) through which comprehensive mental health services are provided—

(A) principally to individuals residing in a defined geographic area (referred to in this title as a 'catchment area');;

(B) within the limits of its capacity, to any individual residing or employed in the catchment area regardless of his ability to pay for services, his current or past health condition or any other factor; and

(C) in the manner prescribed by section 201(b), and

(2) which is organized in the manner prescribed by section 201(c).

This definition replaces the existing definition of a CMHC found in section 401(c) of the existing Act, and for the first time gives a complete, definitional description of a CMHC. It should be noted that the definition and its requirements are to apply to both new CMHCs assisted under the authority of the new title and to the CMHCs assisted under the authority of the title in effect prior to the making of these amendments. However, under other provisions of the title, certain waivers may be granted, as follows:

For CMHCs applying for assistance under the authority of the new title, the requirements of section 201(b) (1), regarding the services to be provided, may be waived for up to two years after initial funding;

For CMHCs assisted under the authority of the title in effect prior to the effective date of these amendments, and which transfer into the new operating grant program authorized under section 203(a), the requirements of section 201(b) (1), may be waived for up to two years after such transfer;

For CMHCs assisted under the authority of the title in effect prior to the effective date of these amendments and which receive continuation grants under the authority of Section 203(e), all of the requirements of Section 201 (b) and (c) may be waived for up to two years.

New section 201(b)—provides that the comprehensive mental health services which must be provided through a CMHC shall include:

(A) inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

(B) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and follow-up services (as prescribed by the Secretary);

(C) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and follow-up services (as prescribed by the Secretary);

(D) consultation and education services which—

(i) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies and other appropriate entities;

(ii) include a wide range of activities (other than direct clinical services) designed to develop effective mental health

programs in the center's catchment area; promote coordination of services delivery among various entities serving the catchment area; increase awareness of residents with respect to the nature of mental health problems and the type of services available; and promote the prevention and control of rape and the proper treatment of the victims of rape;

(E) assistance to courts and other public agencies in screening residents of the center's catchment area who are being considered for referral to a state mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility;

(F) provision of follow-up care for residents of its catchment area who have been discharged from a state mental health facility;

(G) a program of transitional, halfway house services for mentally ill individuals who are catchment area residents and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility; and

(H) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's catchment area, or the need for which in the center's catchment area the Secretary determines is currently being met):

(i) a program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics;

(ii) a program for the prevention and treatment of drug addiction and abuse, and for the rehabilitation of drug addicts, drug abusers, and others persons with drug dependency problems.

The various services described above can be compared to the present requirement that CMHCs provide "essential services", including inpatient services, outpatient services, partial hospitalization services, emergency services, and consultation and education services. Each of these is included in the above list with the clear intent that CMHCs are to continue to provide this minimum set of services.

The definition of consultation and education services has been greatly expanded in order to clarify the purposes and extent of these programs. The education program of the CMHC has at least two major functions. First, its goal is to increase the visibility, identifiability, and accessibility of the CMHC for all residents of the catchment area. Second, it should promote mental health and prevent emotional disturbance through the distribution and dissemination of relevant mental health knowledge.

Consultation and education services must be coordinated with all other center activities. Through effective consultation and education, the center will receive more appropriate referrals, enable other caregivers to manage their clients more effectively, and enhance continuity of care, as well as extend service to underserved groups in the catchment area.

While consultation and education include a range of activities aimed at promoting coordination among community agencies and develop-

ing effective mental health programs throughout the community, it specifically excludes the provision of direct clinical services. All services other than direct clinical services, however, are not appropriately labeled consultation and education. Staff training, community organization, and fund raising activities, for example, may be relevant community mental health center activities, but they are not legitimately defined as consultation and education.

The provisions in subparagraphs (E), (F) and (G), for assistance by CMHCs with screening of catchment area residents being considered for inpatient treatment in mental health facilities and for follow-up care for such persons, including where appropriate transitional halfway house services, are designed to encourage the use of CMHCs in statewide mental health programs and to discourage the inappropriate placement of people in mental health facilities.

The bill specifies that halfway house services are to be "transitional" to emphasize that the required service is designed to assist individuals in their transition from one level of care (such as inpatient care) to another and that halfway houses not serve as long-term care institutions. However, these provisions are not intended to preclude CMHCs from also utilizing these services as alternatives to inpatient care, when appropriate.

For the purposes of this provision, the term "provider of health care services" is to mean an individual—

(A) who is a direct provider of health care in that the individual's primary current activity is the provision of health care or the administration of facilities or institutions in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in administration and is licensed or certified for such provision or administration; or

(B) who is an indirect provider of health care who (i) holds a fiduciary position with, or has a fiduciary interest in any entity engaged in provision of health care, research or instruction or engaged in producing drugs or other articles; (ii) receives more than one-tenth of his gross annual income from fees or other compensation for research or instruction in provision of health care, entities engaged in provision of health care, research or instruction producing or supplying drugs or other articles for use in the provision of research into or instruction in the provision of health care entities engaged in producing drugs or other articles; or (iii) who is a member of the immediate family of an individual described above or is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

The service package described above also includes requirements that CMHCs provide, as part of their basic services, specialized services to children, the elderly, alcoholics, and drug dependent persons. It should be noted that opportunity is provided, with approval of the Secretary, for CMHCs to omit provision of services to alcoholics or drug dependent persons in catchment areas where the need for these services is presently being met. This is done to assure that the programs of the CMHCs are not redundant with existing programs.

New section 201(b) further provides that the provision of comprehensive mental health services through a center shall be coordinated with provision of services by other health and social service agencies (including State mental health facilities) in or serving the center's catchment area to insure that persons needing or receiving services through the center have access to all such health and social services as they may require. CMHC services (a) are to be provided at the center (or satellite centers) through the staff of the center or through appropriate arrangements with health professionals and others in the catchment area, (b) are to be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services, and (c) when medically necessary, must be available and accessible twenty-four hours a day and seven days a week.

New Section 201(c)—Provides that the governing body of a CMHC (except a CMHC operated by a state or local government agency and which received assistance under the authority of the title in effect prior to the making of these amendments) shall be composed, to the extent practicable, of individuals who reside in the center's catchment area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex and place of residence, and other demographic characteristics of the area. The governing body must meet at least once a month, establish general policies for the CMHC (including a schedule of hours during which services will be provided), and approve the CMHC's annual budget and the selection of its director. At least one-half of the members of the governing board are to be individuals who are not providers of health care services.

In the case of CMHCs operated by a state or local government agency and which received assistance under the authority of the title in effect prior to the enactment of these amendments, the above requirements for a governing body need not apply. Such a center shall appoint a committee to advise it with respect to the operation of the CMHC. This advisory committee shall be composed of individuals who reside in the center's catchment area, who are representative of the residents of the area with regard to employment, age, sex, place of residence and other demographic characteristics, and at least half of whom are not providers of health care services.

These provisions are designed generally to insure that a CMHC is governed by a governing body which has a majority of its membership drawn from potential consumers of the services of the center who reside in its catchment area. Further, it is clearly intended that the membership of the governing body be heterogeneous, and broadly representative of the residents of that catchment area.

The qualifying phrase, "where practicable," with respect to the requirement that members of the governing body live within the catchment area of the CMHC is included because the Committee is aware that there are areas in which State or local law or practices may make this provision infeasible or where local governmental bodies or

combinations of local governmental bodies are in the midst of a program to provide comprehensive mental health services throughout their jurisdictions. This would include, for example, Houston, Texas, where the city's various CMHCs are all run by one citywide organization and counties in eastern Nebraska which cooperatively administer services. Generally, while the Committee is responsive to the situation in Houston as an example, this provision is intended to be interpreted narrowly and used rarely. In these cases, it is the intent of the Committee that the Secretary take these special circumstances into account. In every case where a governmental unit serves as the governing board for a center, however, the Committee intends that an advisory committee be appointed in each catchment area as provided in Section 201(c)(1)(B) of the act.

While the Committee insists on the establishment of local governing boards by each community mental health center funded pursuant to the provisions of this new legislation, it recognizes that many CMHCs funded under the legislation to date are operated directly by state or local government agencies, which are prohibited by law from setting up independent consumer governing boards. The Committee has therefore exempted these currently operating centers from this requirement, but has included a stipulation that such centers set up advisory committees, composed of potential consumers who reside in the catchment area, to advise the governmental agency on the operation of the center. While these boards are "advisory" in nature, the Committee nonetheless intends that this provision give potential consumers a real voice in the operation of the CMHC.

This subsection further provides that a center must have established in accordance with regulations prescribed by the Secretary, (A) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, (B) an integrated medical records system (including a drug use profile) which, in accordance with applicable Federal and State laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient, (C) a professional advisory board, which is composed of members of the center's professional staff, to advise the governing board in establishing policies governing medical and other services, and (D) an identifiable administrative unit which is responsible for providing the consultation and education services described in subsection (b)(1)(D). The Secretary may waive the requirements of clause (D) for any center if he determines that because of its size, or other relevant factors, the establishment of the administrative unit described in clause (D) is not warranted.

With respect to confidentiality, as the Secretary in regulations and the CMHCs in practice develop means of assuring confidentiality, the Committee intends that the requirements for protection of confidentiality which were included in the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act by the amendments of 1974 should be followed unless reason for a specific exception is found.

GRANTS FOR PLANNING COMMUNITY MENTAL HEALTH CENTER
PROGRAMS

New section 202(a)—Provides that the Secretary may make grants to public and non-profit private entities to carry out projects to plan CMHC programs. In connection with such a project for an area the grant recipient is to (1) assess the needs of the area for mental health services, (2) design a CMHC program for the area based on such an assessment, (3) obtain within the area financial and professional assistance and support for the program, and (4) initiate and encourage continuing community involvement in the development and operation of the program. The amount of any such grant may not exceed \$75,000.

New section 202(b)—Provides that a grant under section 202(a) may be made for not more than one year, and, if a grant is made under such section for a project, no other grant may be made for such project under such section.

New section 202(c)—Requires the Secretary in making grants under this section to give special consideration to applications submitted for projects for CMHC programs in areas designated by the Secretary as urban or rural poverty areas. Prohibits grants being made under this section unless the application has been recommended for approval by the National Advisory Mental Health Council. Generally, it is anticipated that the provision requiring special consideration for poverty area projects will mean that all approvable applications from areas designated as poverty areas would be funded in preference to approvable applications from areas not designated as poverty areas.

New section 202(d)—Authorizes appropriations for payments under grants under this section of \$3.75 million for fiscal year 1975, and \$3.75 million for fiscal year 1976.

GRANTS FOR INITIAL OPERATION OF CENTERS

New Section 203(a)—Authorizes the Secretary to make grants to assist in meeting the costs of operation (other than costs related to construction) for—

- (A) public and non-profit CMHCs and
- (B) any public or nonprofit private entity which:
 - (i) Is providing mental health services;
 - (ii) Meets the requirements of section 201, except that it is not providing all of the comprehensive services described in that section;
 - (iii) Has a plan satisfactory to the Secretary to provide all such comprehensive services within two years after receiving the first grant under this subsection;

This section authorizes grants to CMHCs which meet the definition of a center under section 201, and also to entities which meet all the requirements of section 201 except that they do not provide fully comprehensive services. However, such entities must satisfy the Secretary that they will, within two years of receiving an operating grant under this section, expand their program so as to meet all the services requirements under this legislation.

Grants to entities which do not meet the definition of a CMHC under this legislation are to be made to programs which offer many of the

services required under section 201(b) and which intend to become fully comprehensive CMHCs. The two-year period should be used by such entities to gradually expand and build up their program, as fast as their resources allow.

The Committee believes that it is unrealistic to expect all CMHCs to be able to provide the full range of services required under this legislation from their first day of operation. Lead time is necessary to enable adequate staff to be recruited, proper facilities found and equipment purchased. While this is being done, under the Committee bill, the community will be receiving services—albeit not fully comprehensive services.

This lead time will also give the CMHC an opportunity to establish itself within the community and to educate the community about its services. Experience shows that after a few years of operation centers experience greatly increased demands for their services, as the community learns of and accepts the CMHC. The Committee was concerned that if all centers were required to offer fully comprehensive services from the first day of operation, many of the services would be grossly underutilized for months, and possibly years. This is both inefficient and costly.

The subsection further provides that grants under this section may be made for a grantee's costs of operation during the first eight years after its establishment. In the case of a CMHC, or other entity, assisted under the authority of the title in effect prior to the making of these amendments, such CMHC or entity will be considered as having been in operation for a number of years equal to the sum of the number of grants it received under such title, and the number of grants it has received under this subsection.

For purposes of these calculations, only the first series of grants awarded under the previous authority will be counted. Any growth grants received by the CMHC or entity will be disregarded.

Present law provides assistance to CMHCs only for the costs of staffing. The Committee has broadened this support to include all of the operating costs of a center since it is recognized that the present limitation to staffing costs has often created inappropriate incentives and pressure on the centers to increase their staffing in an artificial manner.

New section 203(b)—Provides that each grant under this section to a CMHC shall be made for the costs of its operation for the one-year period beginning on the first day of the first month for which such grant is made. No center is to receive more than eight grants under this section. No entity which fails to meet the definition of a CMHC under Section 201 may receive more than two grants under this section. In determining the number of grants that a CMHC has received under this section, any grants awarded to the entity under the provisions of subsection (a)(1)(B)—for entities not providing fully comprehensive services—shall be included.

New section 203(c)—Limits the amount of any grant under this section to the lesser of two amounts, as follows:

- (1) The amount by which the grantee's projected costs of operation for that year exceed the total of State, local and other funds and of fees, premiums and third-party reimbursements

which the grantee may reasonably be expected to collect in that year; or

(2) (A) For a CMHC which does not serve an urban or rural poverty area, an amount equal to 80 per centum of its operating costs for the first year of its operation, 65 per centum of such costs for the second year of its operation, 40 per centum of such costs for the third year of its operation, 35 per centum of such costs for the fourth year of its operation, 30 per centum of such costs for the fifth and sixth years of its operation, and 25 per centum of such costs for the seventh and eighth years of its operation;

(B) For a CMHC providing services in an urban or rural poverty area, an amount equal to 90 per centum of its operating costs for the first and second years of its operation, 80 per centum of such costs for the third year of its operation, 70 per centum of such costs for the fourth year of its operation, 60 per centum of such costs for the fifth year of its operation, 50 per centum of such costs for the sixth year of its operation, 40 per centum of such costs for the seventh year of its operation, and 30 per centum of such costs for the eighth year of its operation.

This two-part formula is designed to facilitate an easy adjustment to expanded public or private third party collections by CMHCs. The Committee bill includes new requirements that centers aggressively pursue such funding to supplement their federal grants and, to the maximum feasible extent, replace federal funding so the CMHC can become fully self-supporting.

As public and private insurance coverage increases, many centers will be able to drop out of the operating (and the financial distress) grant programs under this two-part formula. As soon as such coverage increases, federal contributions under the operating grant (and the financial distress grant) will drop, and possibly operating grants will be reduced to zero before the end of the center's eight year grant period. This mechanism will also ensure a smooth transition to national health insurance, should such a plan be enacted.

The Committee anticipates that in calculating the amount under subparagraph (A) above, each applicant's financial situation will be reviewed individually, and that in each case, a grant will be made only after a review of reasonable projections with respect to a CMHC's ability to collect fees and revenues from other sources.

The percentage levels set in subparagraph (2) differ from those in the present law in that they decline more evenly over the years and in the last year reach 25 per centum of operating costs for nonpoverty centers and 30 per centum for poverty centers, rather than the present final percentage of 30 per centum for nonpoverty centers and 70 per centum for poverty centers.

These levels are also higher in the first two years than under existing law because it is recognized that support from non-Federal sources is usually not available for starting CMHCs. The new lower figure for support in the last year is intended by the Committee to make the final termination of Federal support less disruptive to the CMHCs than is presently the case.

Finally, this subsection provides that in any year during which the center receives a consultation and education grant under section 204, the costs of its consultation and education services, and the revenue

received for such services from other sources, will not be counted in computing the center's operating grant.

New section 203(d)—Authorizes appropriations for payments under initial grants under this section of \$50 million for fiscal year 1976, and \$55 million for fiscal year 1977. Authorizes appropriations for the fiscal year 1977, and for each of the succeeding seven fiscal years, of such sums as may be necessary to make payments under continuation grants under this section to CMHCs and other entities which first received an initial grant under this section in fiscal year 1976, or the next fiscal year, and which are eligible for a grant under this section in a fiscal year for which sums are authorized under this subsection.

Initial grants in this context are understood to be a grant made for the first year of the eight year period of support authorized. Each of the succeeding grants is then a continuation grant.

New section 203(e)—Authorizes continuation grants to entities which received staffing, children's services, alcoholism and/or drug abuse grants under section 220, 242, 243, 251, 256, 264, or 271 of the title in effect prior to the making of these amendments, and which would still be eligible for such a continuation grant under that title. These continuation grants may be made in lieu of an operating grant under subsection (a). Such grants will be made—

(A) For the same number of years and amount prescribed for the grant under the repealed section of the present law, except that—

the entity may not receive more than two continuation grants unless it meets the requirements of section 201, and

the total amount received for any year (as determined by the Secretary) under the total of the grants made under this subsection may not exceed the difference between the agency's costs of operation for the year and the total of State, local and other funds, and of the fees, premiums and third-party reimbursements which the agency may reasonably be expected to collect during that year; and

(B) in accordance with any other terms and conditions applicable to such a grant.

This subsection further provides that in any year during which the center receives a consultation and education grant under section 204, the staffing costs associated with the consultation and education services and the revenue received for such services from other sources will not be counted in computing the center's continuation grant under this subsection.

This subsection authorizes the continuation of grants made under the present law, in accordance with the conditions for such grants under the law. The Committee recognizes that the federal government has made a commitment to these entities, and that it is unrealistic to expect them all to be immediately able to adapt their programs to meet all the conditions under the new legislation. However, the Committee has limited these continuation grants to a period of no more than two years unless the entities meet all the requirements of section 201.

The Committee believes it is essential that all entities assisted under this legislation meet the definition of a center in section 201, or be planning to meet such definition within a reasonable period of time.

The Federal government cannot support a two-tier system of CMHC services—one group of centers funded under the present law and meeting only those requirements for CMHCs under that law, and a second group of fully comprehensive centers meeting the new, expanded definition of a CMHC under this legislation.

Entities funded under the present law must meet the new definition of a CMHC in this legislation within two years or they will be ineligible for a continuation grant under this section, an operating grant under section 203(a), a consultation and education grant under section 204 or facilities grant under Part C.

Section 203(e) further prohibits grantees which have received a continuation grant under this subsection from receiving an initial operating grant under section 203(a).

Finally, the subsection authorizes appropriations for the fiscal year 1976, and each of the next six fiscal years, of such sums as may be necessary to make grants under this subsection.

GRANTS FOR CONSULTATION AND EDUCATION SERVICES

New section 204(a)—Provides that the Secretary may make annual grants for the costs of providing the consultation and education services described in section 201(b)(1)(D) to any CMHC which:

(A) received for a fiscal year ending before July 1, 1975, a staffing grant under section 220 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975) and may not, because of limitations respecting the period for which grants under that section can be made, receive an additional grant under section 203(e); or

(B) received, or is receiving, a grant under section 203, and has been in operation (determined in accordance with section 203(a)(2)) not less than four years (or not less than two years if the Secretary determines that, without a grant under this section, the CMHC will be unable to adequately provide the consultation and education services in section 201(b)(1)(D) during the third or fourth years of its operation).

This subsection also provides that the Secretary may make annual grants for consultation and education services to any public or non-profit private entity:

(A) which has not received any grant under this title (other than a grant under this section as amended by these amendments);

(B) which meets the requirements of section 201 respecting the organization and services of CMHCs except, in the case of an entity which has not received a grant under this section, the requirement for the provision of consultation and education services; and

(C) the catchment area of which is not within (in whole or in part) the catchment area of a CMHC.

Thus, this provision provides for the award of an annual grant to defray the costs of the consultation and education services to any of three types of CMHCs: those which were assisted under the existing law and are either in their last year of assistance or have completed their period of assistance; those which were assisted under the existing

law or under the new legislation and which have been in operation for four years (or for at least two years if without consultation and education grant they could not provide such services); and those which have not received assistance under either law but conform to all of the requirements of section 201 respecting the organization and operation of CMHCs except for the requirement that they provide consultation and education services.

Support for the costs of consultation and education services has been designed to overlap the general operating (or staffing) grant of a CMHC by several years to ensure that CMHCs do not neglect these important services. One of the difficulties in developing consultation and education programs in the past has been that the pressure of establishing direct clinical services has resulted in a relative neglect of the indirect services. Without special attention to consultation and education programs, there is no real incentive for centers to develop well articulated and defined programs, particularly in the early years of operation.

The overlap between operating (or staffing) grants and consultation and education grants will also enable an orderly transition to be made from one form of support to the other when the eight year term of the general support grant is over, and enable the CMHC to engage in stable long-range planning efforts. It is intended that the support for a center for consultation and education services will be permanent unless it either ceases to conform to the requirements of section 201 respecting its operation and organization or the Committee terminates the program because adequate coverage in insurance and other plans for such services has become available.

Support for consultation and education services beyond the period for which support is offered for general purposes has been included in the law by the Committee because it realizes that payment for such services is not generally available to the centers under third party reimbursement plans or other sources of financing, and because the services are an integral part of comprehensive community mental health programs. Consultation and education services are preventive services. They facilitate the early detection of mental and emotional problems in children and adults, and thus benefit the mental health of the entire community.

Furthermore, by providing continuing support for such services the Committee can maintain the overall quality of the CMHC program. Thus, since recipients of these grants must continue to meet the various requirements of CMHCs contained in the legislation, the availability of these grants will help to insure that once Federal funds are no longer available for the general operating costs of the centers, these centers will continue to offer comprehensive services, to establish and maintain linkages with other health and social service agencies, and to serve the needs of their catchment areas. Since the grants would also be available to centers which have not previously received Federal funds, having been supported by State or local funds or started by a private organization, the grants will provide an incentive to these organizations to meet the requirements and standards for CMHCs included in the legislation.

New section 204(b)—Provides that the amount of any grant made under section 204(a) is to be determined by the Secretary, may not exceed 100 per centum of the center's costs of providing consultation

and education services during the year for which the grant is made, and may not exceed:

(1) in the case of each of the first two years for which a center receives a grant, the sum of (A) an amount equal to the product of 50¢ and the population of the center's catchment area, and (B) the lesser of (1) one-half the amount determined under clause (A) or (2) one-half of the amount received by the center in such year for charges for the provision of such services;

(2) in the case of the third year for which a center receives a grant, the sum of (A) an amount equal to the product of 50¢ and the population of the center's catchment area, and (B) the lesser of (1) one-half the amount determined under clause (A), or (2) one-fourth of the amount received by the center in such year for charges for the provision of such services;

(3) in the case of the fourth year and each subsequent year thereafter for which a center which does not make services available to persons in an area designated by the Secretary as an urban or rural poverty area receives such a grant, the lesser of (A) the sum of (i) an amount equal to the product of $12\frac{1}{2}$ ¢ and the population of the center's catchment area, and (ii) one-eighth of the amount received by the center in such year from charges for the provision of such services, or (B) \$50,000; and

(4) in the case of the fourth year and each subsequent year thereafter for which a center which provides services to persons in an area designated by the Secretary as an urban or rural poverty area receives such a grant, the sum of (A) an amount equal to the product of 25¢ and the population of the center's catchment area, and (B) the lesser of (i) the amount determined under clause (A), or (ii) one-fourth of the amount received by the center in such year for charges for the provision of such services.

For the purposes of this section the term "center" is understood to include the entities described in section 204(a) which are eligible for these grants in that they have not received support as CMHCs, but do conform to the requirements for CMHCs except for the requirement for the provision of consultation and education services.

These requirements for determining the amounts of consultation and education grants are based on a two-part formula which includes:

(1) a "capitation payment" based upon the total population of the center's catchment area, and

(2) an "incentive payment" based upon the amount of funds the center succeeds in collecting from charges to other agencies for its consultation and education services.

The use of an incentive payment is intended by the Committee to encourage the centers to attempt as aggressively as possible to collect from agencies to which they provide consultation and education services reasonable payment for these services. It is not presently common practice for agencies to pay for these services, but since they are valuable and are to be the subject of continued Federal support the Committee has included mechanisms designed to encourage the creation of payment mechanisms for them. Keved to this incentive payment structure is a declining level of support for consultation and education services over the course of the first four years for which

it is available. After the initial four-year period, the available level of support would be constant although it could be increased by a center through more successful collection of charges for services. In the first three years grants to centers providing services to poverty and non-poverty areas would be based upon the same formula. Subsequently the poverty centers would receive a higher payment in recognition of the fact that it is harder for these centers to obtain reimbursements; however, no center could receive a grant in excess of total operating costs. The formulae for determining the amount of a center's grant, on a year-by-year basis, are set forth below.

Population=total population of the catchment area.

ARC=amount received by the center in charge for its consultation and educational services in the year for which the grant is made.

First and second year of consultation and education grants.—Grant amount = $[\$0.50 \times \text{population}] + [\text{the lesser of: } (\$0.50 \times \text{population}) \text{ or } \frac{\text{ARC}}{2}]$

Third year.—Grant amount = $[\$0.50 \times \text{population}] + [\text{the lesser of: } (\$0.50 \times \text{population}) \text{ or } \frac{\text{ARC}}{4}]$

Fourth and subsequent years (nonpoverty centers).—Grant amount = the lesser of: $[\$0.25 \times \text{population}] + \frac{\text{ARC}}{8}$ or \$50,000

Fourth and subsequent years (poverty centers).—Grant amount = $[\$0.25 \times \text{population}] + [\text{the lesser of: } (\$0.25 \times \text{population}) \text{ or } \frac{\text{ARC}}{4}]$.

New section 204(c)—authorizes appropriations for payments under consultation and education grants under section 204 in the amount of \$10 million for fiscal year 1976, and \$15 million for fiscal year 1977.

CONVERSION GRANTS

New Section 205(a)—Authorizes the Secretary to make grants to public or nonprofit entities for their reasonable costs in providing any of the mental health services described in section 201(b)(1) which they did not provide before the date of enactment of these Amendments, provided that these entities—

(1) have an approved application for a grant under section 203 (operating) or 211 (financial distress); and

(2) can reasonably be expected to have an operating deficit for the period for which the grant is or will be made, which is greater than the amount of the grant the entity will receive.

The term 'projected operating deficit' is defined to mean the excess of projected costs of operation (including the costs related to the provision of services for which a conversion grant is to be made) for a particular period over the total amount of State, local and other funds (including funds under grants under section 203, 204 or 211) received by the entity during that period, and the fees, premiums and third-party reimbursements to be collected by the entity during that period.

The conversion grant authority is included to enable existing centers to expand their services in order to meet the new definition of a

CMHC under this legislation. This authority is intended to implement the Committee's intent that all CMHCs receiving Federal assistance meet the same high standards.

Since existing regulations requires centers to provide only the five basic services (inpatient, outpatient, partial hospitalization, emergency and consultation and education) these funds will be used by existing centers to provide the other services required under section 201(b)(1). The legislation requires these centers to meet the new definition within two years, or lose their federal support. The Committee feels it would be unrealistic, and unfair, to make such requirements of the existing centers without providing a mechanism to assist them expand their programs and set up the new required services.

New section 205(b)—Requires that conversion grants be made for the same period as the center's grant under section 203 or 211 will be made.

Limits the amount of any conversion grant to only that part of the applicant's operating deficit which is reasonably attributable to providing the new services for which a conversion grant is made.

New section 205(c)—Authorizes appropriations for conversion grants of \$20 million for fiscal year 1976 and \$20 million for fiscal year 1977.

GENERAL PROVISIONS RESPECTING GRANTS UNDER THIS PART

New section 206(a)—provides that no grant under this part to any entity or CMHC in any State unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237.

The requirement that a State plan be approved prior to making grants under this part for development, operation, or consultation and education services of CMHCs is intended to assure that when State mental health authorities review grant applications as required by section 206(d) that they do so in the context of their State plan for the provision of mental health services within the State, and the program contained in that plan for CMHCs throughout the State.

New Section 206(b): Stipulates that no grant may be made under this part, unless an application meeting the requirements of Section 206(c) has been approved by the Secretary.

New Section 206(c) provides that applications are to be submitted in such form and manner as the Secretary prescribes and to contain such information as he requires.

Requires an application for a grant for the operation of a CMHC under section 203, for the continuation under section 203 of a grant made under the present law, for consultation and education services under section 204 or for conversion under section 205, to contain or be supported by the following assurances (except that these requirements may be waived for one year in accordance with paragraph (3)):

(A) the CMHC for which the application is submitted will provide, in accordance with regulations of the Secretary (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for developing, compiling, evaluating and reporting to the Secretary statistics and other information (which the Secretary is to publish and disseminate on a

periodic basis and which the center is to disclose at least annually to the general public) relating to—

- (I) the cost of the center's operation,
- (II) the patterns of utilization of its services,
- (III) the availability, accessibility, and acceptability of its services,
- (IV) the impact of its services upon its catchment area, and
- (V) such other matters as the Secretary may require;

(B) the CMHC for which the application is made will, in consultation with the residents of its catchment area, review its program of services and the statistics and other information referred to in subparagraph (A) to assure that its services are responsive to the needs of the residents of the catchment area;

(C) to the extent practicable, such CMHC will enter into cooperative arrangements with health maintenance organizations (HMOs) serving residents of the center's catchment area for the provision through the center of mental health services for the members of such organizations under which arrangements the charges to the HMOs for such services shall be not less than the actual costs of the center in providing such services;

(D) if the CMHC serves a population with a substantial proportion of limited English-speaking individuals, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services, to the extent practicable, in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both the English language and the language most appropriate to such individuals and whose responsibilities include giving guidance to such individuals and to appropriate staff members regarding cultural sensitivities and bridging linguistic and cultural differences;

(E) the CMHC requires the health care of every patient to be under the supervision of a member of the professional staff and has provided for having a member of the professional staff available to furnish care in case of emergency;

(F) the CMHC has appropriate methods and procedures for dispensing and administering drugs and biologicals;

(G) in the case of an application for a grant under section 203 for a CMHC which will serve an urban or rural poverty area, the applicant will use the additional grant funds it receives because of its poverty designation to serve persons in the catchment area who are unable to pay;

(H) such CMHC will develop a plan for, and use its best efforts to insure that adequate financial support will be available to the center from Federal sources (other than those available under this part) and non-Federal sources, including to the maximum extent feasible, reimbursement for the recipients' consultation and education services and screening services provided in accordance with sections 201(b)(1)(D) and 201(b)(1)(E), so that the center will be able to continue to provide comprehensive mental health services when financial assistance provided under this part is reduced or terminated, as the case may be;

(I) such CMHC (i) has or will have a contractual or other arrangement with the State Medicaid agency for the payment of all or part

of the center's costs in providing health services to persons eligible for Medicaid, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

(J) such CMHC has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons entitled to insurance benefits under Medicare, to medical assistance under Medicaid, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(K) such CMHC (i) has prepared a schedule of fees or payments for its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied on the basis of the patient's ability to pay and (ii) has made and will continue to make every reasonable effort—

(I) to secure payment for services in accordance with such schedules from all patients,

(II) to collect reimbursement for services to persons eligible for Medicare or Medicaid coverage, or to coverage under any other public assistance or private health insurance program, on the basis of the full amount of fees and payments without application of any discount, and

(III) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph; and

(L) such CMHC will adopt and enforce a policy (i) under which fees for the provision of mental health services through the center will be paid to the center, and (ii) which prohibits health professionals who provide services to patients through the center from providing such services to such patients through the center.

These provisions are intended to assure that CMHCs make every effort to become self-supporting through proper billing and collection procedures for their services.

CMHCs are expected to aggressively pursue all available third party payments (including those financed entirely or partly by the federal government), and to make every effort to ensure that all patients pay for services, according to their ability.

The Committee emphasizes that CMHC's are entitled to collect from all third party payors the full fee or payment for services (to the extent such service is covered under the insurance policy or assistance program). The Committee is disturbed by reports that some private insurance companies do not reimburse CMHCs for the full cost of providing services on the basis that the CMHC Act requires centers to provide services to all in need, regardless of ability to pay. It is not the Committee's intent that the CMHC grant program subsidize private health insurance; and under the terms of these amendments (subparagraph (K) above) this is expressly prohibited.

The Committee is also disturbed that CMHCs are not being fully reimbursed for services to individuals eligible for services under federal third-party payment programs (notably Medicaid and social services programs authorized under the Social Security Act). Apparently, the rationale for policy is the obligation of all CMHC's receiving assistance under this legislation to provide services to all, regardless of ability to pay, and that the Federal government would be paying

twice for the same service of CMHCs receive full reimbursement from federal third party payment programs. However, such a ruling totally negates the Committee's policy that funds under the CMHC Act be used as seed money to initiate new programs which will become fully self-supporting as soon as possible. Grants under the CMHC Act do not cover 100% of the costs of services, even in the first year. Thus, centers must be entitled to all available alternative funding even while they continue to receive grants under the legislation.

Under the two part formula for operating grants, provision has been made by the Committee for reducing the Federal grants in accordance with third party payments raised. Hence, there is no possibility of the Federal government paying twice for the same service.

The Committee therefore expects the Secretary to make every effort to ensure that CMHCs receive reimbursements to the full extent authorized by law, under all federal third party payment systems administered by HEW, and also to work with other federal departments (such as the Veterans Administration) to maximize repayments to CMHCs for services to individuals eligible for health care services under any federal program.

The Committee also heard testimony that one of the reasons why some centers have found it difficult to become self-supporting is that their patients who are capable of paying for services are siphoned-off into the practices of professionals who work some of their time for the centers, and the rest of the time for themselves. These provisions will prevent this practice by assuring that payment for all services rendered in the centers is made to the centers and that any center patient remains under the care of the center.

This subsection also requires that an application for a grant under section 203 shall also contain a long-range plan for the expansion of the program of the CMHC for which the application is submitted for the purpose of meeting anticipated increases in demand by residents of the center's catchment area for the comprehensive mental health services described in section 201(b)(1). The plan is to include a description of planned growth in the programs of the center, estimates of increased costs arising from such growth, estimates of the portion of such increased costs to be paid from Federal funds, and anticipated sources of non-Federal funds to pay the portion of such increased costs not to be paid from Federal funds.

The subsection further provides that the Secretary may approve an application for a grant under sections 203, 204 and 205 only if the application is recommended for approval by the National Advisory Mental Health Council, meets the various requirements described above, and except as provided in paragraph (3), the Secretary—

(A) determines that the facilities and equipment of the applicant will meet such requirements as he may prescribe;

(B) determines that the application contains or is supported by satisfactory assurances that—

(i) the comprehensive mental health services (in the case of an application for a grant under section 203 or 205) or the consultation and education services (in the case of an application for a grant under section 204) to be provided by the applicant will constitute an addition to, or a significant improvement in the quality (as determined in accordance with

criteria of the Secretary) of services that would otherwise be provided in the catchment area of the applicant;

(ii) federal funds made available under section 203, 204 or 205, as the case may be, will (I) be used to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third-party health insurance payments, that would in the absence of such Federal funds be made available for the applicant's comprehensive mental health services or consultation and education services, as the case may be, and (II) in no event supplant such State, local, and other non-Federal funds;

(iii) in the case of an applicant which received a grant for the preceding fiscal year, determines that during such preceding fiscal year the applicant met, in accordance with the section under which the grant was made, the appropriate requirements of section 201 and complied with the assurances which were contained in or supported the applicant's application for its grant for that year; and

(iv) in the case of an application for a CMHC which will serve a poverty area (ie., the amount of the grant is determined under section 203(c)(2)(B) or 204(b)(3)(B) or under a provision of a repealed section of the law referred to in section 203(e)), the application contains or is supported by assurances satisfactory to the Secretary that the services of the applicant will, to the extent feasible, be used by a significant number of persons residing in an area designated by the Secretary as an urban or rural poverty area and requiring such services. The requirements of this provision, coupled with the requirements of section 206(c)(1)(G), are intended to assure that all CMHCs provide a reasonable volume of services to poor people, that those which receive additional funding because they serve poverty areas devote their additional funding to serving poor people, and that those which receive such additional funding because their catchment area includes poverty areas will actually provide services in such a time, place and manner that these services are used by the residents of the poverty area in question whether or not they individually are poor.

The subsection provides that the Secretary may make one operating or continuation grant to applicants which do not provide the assurances required under section 206(c)(1)(A)-(L), listed above, and without regard to the determinations required by the Secretary under section 206(c)(2), above.

Grants under this provision can be made only in the case of applications for a first grant under section 203(a) for entities not providing fully comprehensive services (i.e., entities described in section 203(a)(1)(B)) or for a first grant under section 203(e), and provided that the applicant gives assurances, satisfactory to the Secretary, that it will undertake during the one year period for which a grant is to be made, any actions necessary to enable it to make the assurances required by subsection (c)(1) and enable the Secretary to make the determinations required by subsection (c)(2), by the end of the one-year period.

This subsection further provides that in each fiscal year for which a CMHC receives a grant under section 203, 204 or 205, the center must obligate for a program of continuing evaluation of the effectiveness of its programs and for a review of the quality of the services provided by it not less than an amount equal to two per centum of the amount obligated by the center in the preceding fiscal year for its operating expenses. The Committee is firmly convinced that all programs assisted with Federal funds should engage in self-evaluation and quality review, but since it is recognized that this will cost money, specific provision is made for the use of Federal grant funds for these activities.

The subsection provides that the costs for which grants may be made under sections 203, 204 or 205 are to be determined in the manner prescribed in regulations of the Secretary, which are to be issued after consultation with the National Advisory Mental Health Council.

Finally, this subsection provides that before the Secretary can disapprove an application under section 203, 204 or 205 (or approve it for an amount which is less than that received by the applicant under such section in the preceding fiscal year) on the grounds that the applicant has not made reasonable efforts to secure payments or reimbursements in accordance with the assurances provided under this section, the Secretary must inform the applicant of how he has failed to make "reasonable efforts" and the way in which his performance can be improved. The Secretary must also give the applicant a reasonable opportunity to respond. Applications which are disapproved, or applications approved for reduced amounts on these grounds must be referred to the National Advisory Mental Health Council for its review and recommendations respecting such approval or disapproval.

The Committee expects that each application will be considered individually, and that the Secretary will make maximum efforts—through technical assistance to the applicant—to improve collection of fees and third party payments where necessary. The Committee expects the Secretary to provide this technical assistance before reducing the amount of the grant awarded under section 203, 204 or 205.

New section 206(d)—requires an application for a grant under part A of the new CMHC Act which is submitted to the Secretary to be submitted at the same time to the State mental health authority for the State in which the project or CMHC for which the application is submitted is located. The State mental health authority is to be the mental health authority designated under section 314(d) of the PHS Act. A State mental health authority which receives an application under this subsection is to review it and submit comments on it to the Secretary within the forty-five-day period beginning on the date it receives the application. The Secretary is to take action to require an applicant to revise his application, or to approve or disapprove an application, within the period beginning on the date the State mental health authority submits its comments to the Secretary or on the expiration of the forty-five-day period in which the State mental health authority may submit comments, whichever occurs first, and ending on the ninetieth day following the date the application was submitted to the Secretary.

These provisions are designed to ensure that State mental health authorities have the opportunity to provide to the Secretary comments on applications from CMHCs submitted to him. Generally these com-

ments should address the extent to which the CMHC application is consistent with the State's mental health plan as required under section 314(d) of the PHS Act and section 237 of the new CMHC Act, the performance of the CMHC to date, and the State's evaluation of it. Second, these provisions are designed to ensure that applications are given expeditious consideration by both the States and the Secretary so that applicants will know within three months of submitting an application whether or not they can plan to receive funding of their application.

New section 206(e)—Provides that not more than two per centum of the total amount appropriated under sections 203, 204 and 205 for any fiscal year is to be used by the Secretary to provide directly through the Department technical assistance for program management and for training in program management to CMHCs which receive grants under such sections, or to entities which receive staffing grants under section 220 of the current CMHC Act beginning before the date of enactment of these amendments.

This provision is intended to increase the emphasis on, and the quality of, program management in CMHCs, an area in which various studies and testimony have described some deficiency in the program to date.

New section 206(f)—Provides that for purposes of subsections (b), (c), (d) and (e) of this section, the term 'community mental health center' includes an entity which applies for or has received a grant under section 203(a), 203(e) or 204(a)(2).

Part B—Financial Distress Grants

GRANT AUTHORITY

New section 211—Authorizes the Secretary to make grants for the operation of CMHC's which (1) received staffing assistance under section 220 of the existing Community Mental Health Centers Act prior to the enactment of these amendments, and because of limitations respecting the period for which grants under section 220 of the present Act may be made, are not eligible for further grants under that section; or received an operating grant or grants under section 203(a) of this title, and because of limitations respecting the period for which grants under that section may be made, are not eligible for further grants under section 203(a); and (2) demonstrate that without a grant under this section there will be a significant reduction in the type or quality of services provided or there will be an inability to provide the services described in section 201(b).

Support for CMHCs under the present Act was intended as seed money to initiate new programs, which would then become fully self-supporting at the end of eight years. However, in reality many of these centers are not receiving adequate reimbursements from third party payors (for various reasons) and at this time of severe financial strain are also finding it impossible to replace the federal staffing grant with alternative state and local government funding.

This situation has caused a number of existing centers to severely curtail services, and even in some cases to completely eliminate consultation and education services.

The Committee is therefore providing short-term additional assistance to these few centers, in order to provide an additional period in which to improve third party collections and to attempt to raise more revenue from the State and local governments. The Committee also hopes that improved coverage under third party payments (such as amendments to Medicaid or a national health insurance plan) will eventually eliminate the need for any long-term support of these, or any other, CMHCs. Thus, the financial distress grant is a stop-gap measure, intended to ensure that the programs built up over the years as a result of Federal aid do not now discontinue their comprehensive services or eliminate services to those who cannot pay or who do not have some form of health insurance. We have already invested too much in these programs to allow this to happen.

GRANT REQUIREMENTS

New section 212(a)—Provides that no grant may be made under section 211 to any CMHC in any State unless the State plan for the provision of comprehensive mental health services within the State has been submitted to, and approved by, the Secretary under section 237. Any grant under section 211 is to be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the CMHC agrees—

(1) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of the center's financial distress;

(2) to conduct a comprehensive cost analysis study in cooperation with the Secretary;

(3) to carry out appropriate operational and financial reforms on the basis of information obtained in the course of the comprehensive cost analysis study or on the basis of other relevant information; and

(4) to use a grant received under section 211 to enable it to provide (within such period as the Secretary may prescribe) the comprehensive mental health services described in section 201(b) and to revise its organization to meet the requirements of section 201 (c) and (d).

Since grants under section 211 are for centers which are in financial distress, these provisions are designed to insure that the Secretary and the center cooperate through financial and operational studies and technical assistance to make whatever corrections in the center's operation will allow it to ease the distress and function without additional financial assistance. Further, since it is recognized that centers funded under the existing Act may not meet the definitional requirements for centers of the new Act, authority is provided whereby grants under section 211 may be used to assist them in meeting such requirements.

New section 212(b)—Requires an application for a grant under section 211 to contain or be supported by the assurances required by section 206(c) (1) (A), (B), (C), (D), (E), (F), (G), (I), (J), (K), and (L), and assurances satisfactory to the Secretary that the applicant will expend for its operation as a CMHC, during the fiscal year for which a grant is sought, an amount of funds (other than funds

for construction), as determined by the Secretary, from non-Federal sources which is at least as great as the average annual amount of funds expended by the applicant for the purpose of operating the center (excluding expenditures of a non-recurring nature) in the three fiscal years immediately preceding the fiscal year for which the grant is sought. The Secretary is not to approve an application unless it has been recommended for approval by the National Advisory Mental Health Council. The requirements of section 206(d) respecting opportunity for review of applications by State mental health authorities and time limitations on actions by the Secretary on the applications are to apply with respect to applications submitted for grants under section 211.

New section 212(c)—Provides that each grant under this section shall be made for the projected costs of operation (except the costs of providing consultation and education services described in section 201 (b) (1) (D)), of such grantee for a one-year period. No CMHC may receive more than three grants under section 211.

New section 212(d)—Provides that the amount of a financial distress grant for any year shall be the lesser of:

(1) the amount by which the CMHC's projected costs of operation for that year exceed the total of State, local and other funds and of the fees, premiums and third-party reimbursements which the center may reasonably be expected to collect in that year; or

(2) a percentage of the CMHC's projected costs of operation for the year, equal to 90 per centum of the maximum percentage of costs authorized for the CMHC's last staffing or operating grant (whichever grant was received last).

AUTHORIZATION OF APPROPRIATIONS

New section 213—Authorizes appropriations under section 211 for financial distress grants of \$15 million for fiscal 1976 and \$15 million for fiscal 1977.

Part C—Facilities Assistance

ASSISTANCE AUTHORITY

New section 221(a)—Requires the Secretary to pay, from allotments made under section 227, the Federal share of projects for:

(1) the acquisition or remodeling, or both, of facilities for CMHCs;

(2) the leasing (for not more than twenty-five years) of facilities for such centers;

(3) the construction of new facilities or expansion of existing facilities for CMHCs, if not less than twenty-five per centum of the residents of the catchment area of the center are members of low income groups (as determined under regulations prescribed by the Secretary); and

(4) the initial equipment of a facility acquired, remodeled, leased, or constructed with financial assistance provided under payments under this part.

Payments are not to be made for construction of a new facility or the expansion of an existing facility unless the Secretary determines

that it is not feasible for the recipient to acquire or remodel an existing facility.

New section 221(b)—Defines for the purposes of this part “Federal share” with respect to projects described in section 221(a) as the portion of the costs of such project to be paid by the Federal government under this part. Further defines for the purposes of this part “Federal percentage”. The definitions of these terms and the provisions of this section are identical to those of sections 401 (h), (i), and (j) of title IV of the existing CMHC Act except for necessary technical revisions and corrections. The Committee has incorporated them at this point in the new Act and repealed existing title IV, but does not intend the substance or effect of these definitions to be changed from that in existing law.

APPROVAL OF PROJECTS

New section 222—Provides conditions and requirements for the approval of construction projects under section 221 by the Secretary. The provisions of new section 222 include and are identical to the provisions of the existing section 205 of part A of title II of the existing CMHC Act with the following exceptions:

(A) each applicant for a construction project is required to provide the various assurances described in section 206(c)(2) with respect to the CMHC for which the application for construction is made;

(B) no application for construction may be approved by the Secretary for a project for a facility for a CMHC or other entity which received a grant under section 220, 242, 243, 251, 256, 264, or 274 of the existing CMHC Act in a fiscal year beginning before the date of enactment of these amendments, unless the Secretary determines that the application is for a project for a center or entity which on completion will be able to significantly expand its services and which demonstrates exceptional financial need for assistance under this part for such project.

These new provisions are designed to assure that centers which receive assistance will meet the requirements of CMHCs imposed by the new Act, and that assistance is not given to existing centers except in exceptional circumstances. Generally, significant expansion of services would require either the opening of a new satellite of an existing center capable of providing an appropriate range of comprehensive mental health services, or at least a doubling of the volume of services which an existing center could provide. Similarly, exceptional financial need would generally be indicated by a demonstration on the part of an existing center that it was unable to raise more than a half of the costs of the proposed construction itself from existing sources.

PAYMENTS

New section 223—Provides terms and conditions for the making or withholding by the Secretary of payments for construction under section 221. The provisions of this section are identical to those of existing sections 403(a), 403(b), and 206 of the present CMHC Act except that technical and conforming changes required by the provisions of

this Act have been made. The original intent and effect of these sections is not changed.

JUDICIAL REVIEW

New section 224—Provides that any State which is denied approval of a construction project application, or its State plan, or is otherwise dissatisfied with actions of the Secretary under sections 223(c) or 237(c) may appeal such actions or decisions to the appropriate United States Court of Appeals. New section 224 is identical to existing section 404 of the present CMHC Act except for technical and conforming amendments, and its original intent and effect is unchanged. It is important to note that section 224 provides for an appeal of any Secretarial decision made with respect to the State's CMHC plan, and not just Secretarial decisions made with respect to facility projects.

RECOVERY

New section 225—Provides conditions under which the United States is entitled to recover construction costs for CMHC facilities constructed with assistance under this part. The provisions of new section 225 are essentially identical to those of existing section 405 of the present CMHC Act with technical and conforming changes. The intent and effect of this section is the same as that of existing section 405.

NON-DUPLICATION

New section 226—Provides that no grant may be made under the PHS Act for the construction or modernization of a facility for a CMHC unless the Secretary determines that there are no funds available under this part for the construction or modernization of such facility.

ALLOTMENTS TO STATES

New section 227—Provides for allotments to the States of funds appropriated under section 228.

New section 227 is identical to existing section 202(a) and (b) of the present CMHC Act except for technical and conforming changes. Its intent and effect are the same as that of the sections which it replaces.

AUTHORIZATION OF APPROPRIATIONS

New section 228—Authorizes appropriations for allotments under section 227 for facility projects of \$5 million for fiscal 1975 and \$5 million for fiscal 1976.

Part D—Rape Prevention and Control

RAPE PREVENTION AND CONTROL

New section 231(a).—Requires the Secretary to establish within the National Institute of Mental Health an identifiable administrative unit to be known as the National Center for the Prevention and Control of Rape (hereinafter referred to as the "Center").

New section 231(b)(1).—Authorizes the Secretary, acting through the Center, to carry out the following directly or by grant:

(A) A continuing study and investigation of—

(i) the effectiveness of existing Federal, State, and local laws dealing with rape;

(ii) the relationship, if any, between traditional legal and social attitudes toward sexual roles, the act of rape, and the formulation of laws dealing with rape;

(iii) the treatment of the victims of rape by law enforcement agencies, hospitals, or other medical institutions, prosecutors, and the courts;

(iv) the causes of rape, identifying to the degree possible social conditions which encourage sexual attacks, and the motives of offenders;

(v) the impact of rape on the victim and the family of the victim;

(vi) sexual assaults in correctional institutions;

(vii) the actual incidence of forcible rape as compared to the reported incidence of forcible rape and the reason for any difference in such incidences; and

(viii) the effectiveness of existing private and local and State government educational, counseling and other programs designed to prevent and control rape.

(B) The compilation, analysis, and publication of summaries of the continuing study conducted under subparagraph (A) and the research and demonstration projects conducted under subparagraph (E). The Secretary is required to submit annually to the Congress a summary of such study and projects together with recommendations where appropriate.

(C) The development and maintenance of an information clearing-house with regard to (i) the prevention and control of rape; (ii) the treatment and counseling of the victims of rape and their families; and (iii) the rehabilitation of offenders.

(D) The compilation and publication of training materials for personnel who are engaged or intended to engage in programs designed to prevent and control rape.

(E) Assistance to community mental health centers and other qualified public and nonprofit private entities in conducting research and demonstration projects concerning the prevention and control of rape, including projects (i) for the planning, developing, implementing, and evaluating of alternative methods used in the prevention and control of rape, the treatment and counseling of the victims of rape and their families, and the rehabilitation of offenders; (ii) for the application of such methods; and (iii) for the promotion of community awareness of locations in which and conditions under which sexual attacks are likely to occur.

(F) Assistance to community mental health centers in meeting the costs of providing consultation and education services respecting rape.

New section 231(b)(2).—Provides that for purposes of this subsection, the term 'rape' includes statutory and attempted rape and any other criminal sexual assault (whether homosexual or heterosexual) which involves force or the threat of force.

New section 231(c).—Requires the Secretary to appoint an advisory committee to advise, consult with, and make recommendations to him on the implementation of subsection (b). Further requires the Secretary to appoint to this committee persons who are particularly qualified to assist in carrying out the functions of the committee. A majority of the members of the committee must be women. Members of the advisory committee are to receive compensation at rates not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule for each day (including travel time) they are engaged in the performance of their duties as members of the advisory committee, and while so serving away from their homes or regular places of business, each member is to be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as is authorized by section 5703 of title 5 of the United States Code for persons in Government service employed intermittently.

New section 231(d).—Authorizes, for the purpose of carrying out subsection (b), appropriations of \$7 million for fiscal year 1976 and \$10 million for fiscal year 1977.

PART E—GENERAL PROVISIONS

DEFINITIONS

New section 235—Defines for the purposes of this title the terms:

(1) "State" as including the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia;

(2) "State agency" as the State mental health authority responsible for the mental health service part of a State's plan under section 314 (d) of the PHS Act. This use of the same State agency for purposes of both section 314(d) of the PHS Act and the CMHC Act is intended to increase the coordination of mental health activities at the State level;

(3) "Secretary" as the Secretary of Health, Education, and Welfare; and

(4) "National Advisory Mental Health Council" as the National Advisory Mental Health Council established under section 217 of the PHS Act.

REGULATIONS

New section 236—Specifies that regulations issued by the Secretary for the administration of this title are to include, among other things, provisions applicable uniformly to all the States which:

(1) prescribe the general manner in which the State agency of the State shall determine the priority of projects for CMHCs on the basis of the relative need of the different areas of the State for such centers and their services and requiring special consideration for projects on the basis of the extent to which a center to be assisted or established upon completion of a project (A) will, alone or in conjunction with other centers owned or operated by the applicant for the project or affiliated or associated with the applicant, provide comprehensive mental health services for resi-

dents of an urban or rural poverty area or (B) will be part of or closely associated with a general hospital;

(2) prescribe general standards for facilities and equipment for centers of different classes and in different types of location; and

(3) require that the State plan of a State submitted under section 237 provide for adequate CMHCs for people residing in the State, and provide for adequate CMHCs to furnish needed services for persons unable to pay therefor.

The National Advisory Mental Health Council is to be consulted by the Secretary before the issuance of regulations under this section.

New section 236 is similar to existing section 203 of the present CMHC Act but has been amended to conform it to the text of the new Act.

STATE PLAN

New section 237(a)—Requires a State plan for the provision of comprehensive mental health services within a State which wishes to receive assistance under this title. The State plan is to be comprised of two parts: an administrative part, and a services and facilities part.

The requirements of new section 237 are similar to those of existing section 204 in the present CMHC Act except that emphasis is given to the plan as a plan for comprehensive mental health services generally, rather than simply for construction of mental health facilities. The administrative part of the plan is to contain provisions respecting the administration of the plan by the State and related matters. In particular, the administrative part is to:

(A) provide for the designation of a State advisory council to consult with the State agency in administering the plan. The council is to include (i) representatives of nongovernment organizations or groups, and of State agencies concerned with planning, operation or use of CMHCs or other mental health facilities, and (ii) representatives of consumers and providers of the services provided by such centers and facilities who are familiar with the need for such services;

(B) provide that the State agency will make reports in such form and containing such information as the Secretary from time to time reasonably requires, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the reports;

(C) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

(D) include provisions meeting such requirements as the Civil Service Commission may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

The services and facilities part of the State plan is to contain provisions respecting services to be offered within the State by CMHCs and provisions respecting facilities for such centers. As such, the services and facilities part is to:

(A) be consistent with the mental health services part of the State's plan under section 314(d) of the PHS Act. Since the 314(d) plans is to be consistent with the plan for health services

in the State required by section 314(a), the CMHC plan must also be consistent with the requirements of the 314(a) plan;

(B) set forth a program for CMHCs within the State (i) which is based on a statewide inventory of existing facilities and a survey of need for the comprehensive mental health services described in section 201(b); (ii) which conforms with the regulations prescribed by the Secretary under section 236; and (iii) which provides for adequate CMHCs to furnish needed services for persons unable to pay therefor;

(C) set forth the relative need, determined in accordance with the regulations prescribed under section 236, for the projects included in the program described in subparagraph B, and, in the case of projects under part C of the Act, provide for the completion of such projects in the order of such relative need;

(D) emphasize the provision of outpatient services by CMHCs as a preferable alternative to inpatient hospital services; and

(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title.

New Section 237(b)—Requires the State mental health authority designated under section 314(d) of the PHS Act administer or supervise the administration of the State plan.

New section 237(c)—Requires States to submit State plans in such form and manner as the Secretary prescribes in regulations, and requires the Secretary to approve any State plan (and any modification thereof) which complies with the requirements of section 237(a). The Secretary is not to finally disapprove a State plan except after reasonable notice and opportunity for hearing to the State.

New section 237(d)—Provides that States may use a fraction of their allotments under section 227 for the cost of administration of the State plan. New section 237(d) is identical to existing section 403(c) of the present CMHC Act except for technical and conforming amendments. Its intent and effect are the same as those of section 403(c).

CATCHMENT AREA REVIEW

New section 238—Requires each State health planning and development agency designated under section 1521 of the PHS Act, in consultation with the State's mental health authority, to review periodically the catchment areas of the CMHCs located in the State to (1) insure that the sizes of such areas are such that the services to be provided through the centers (including their satellites) serving the areas are available and accessible to the residents of the areas promptly, as appropriate, (2) insure that the boundaries of such areas conform, to the extent practicable, with the relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (3) insure that the boundaries of such areas eliminate, to the extent possible, barriers to access to the services of the centers serving the areas, including barriers resulting from an area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

STATE CONTROL OF OPERATIONS

New section 239—Provides that the States shall control their own operations under this title. This section is identical to existing section 406 of the present CMHC Act except for technical and conforming amendments.

RECORDS AND AUDIT

New section 240—Requires that the recipients of assistance under this title keep appropriate records and authorizes the Comptroller General to have access to records for the auditing purposes. This section is identical to existing section 408 of the present CMHC Act except for technical and conforming amendments.

NON-DUPLICATION

New section 241—Provides that grants shall not be made under this title for purposes for which other Federal support is available. This section is identical to existing section 409 of the present CMHC Act except for technical and conforming amendments.

DETERMINATION OF POVERTY AREA

New section 242—Provides guidelines for the Secretary for his determination of poverty areas. This section is identical to existing section 410 of the present CMHC Act except for technical and conforming amendments.

PROTECTION OF PERSONAL RIGHTS

New section 243—Requires the Secretary in making grants under parts A and B of the new CMHC Act to take such steps as may be necessary to assure that no individual is made the subject of any research involving surgery which is carried out (in whole or in part) with funds under grants under such parts unless the individual explicitly agrees to become a subject of such research.

The Committee has been concerned with the growth of psychosurgery in this country and intends by this provision to assure that no funds available under this Act are used to support psychosurgery except in situations where the subject of such surgery himself is competent to agree to it, understands its purpose and possible effects, and has himself explicitly consented to the performance of the surgery.

REIMBURSEMENT

New section 244—Requires the Secretary, to the extent permitted by law, to work with States, private insurers, CMHCs, and other appropriate entities to assure that CMHCs are eligible for reimbursement for their mental health services to the same extent as general hospitals and other licensed providers.

SHORT TITLE

New section 245—Provides that the amended title II of the Mental Retardation Facilities and Community Mental Health Centers Con-

struction Act of 1963 may be cited as the "Community Mental Health Centers Act".

Section 305(a)—Requires the Secretary, not less than one year after the date of enactment of this Act, to submit a report to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate setting forth a plan, to be carried out in a period of five years, for the extension of comprehensive mental health services through CMHCs to persons in all areas in which there is a demonstrated need for such services. Such plan is to indicate, at a minimum, on a phased basis the number of persons to be served by such services and an estimate of the costs of personnel requirements needed to provide the services.

This requirement reflects the Committee's view that it does not consider CMHCs as a demonstration program. It is the Committee's intent that within the next five years the entire nation be served by an appropriate network of centers, assisted through the seed money provided for under section 203 of the new CMHC Act. Since the present Administration has indicated that it feels that CMHCs are some form of demonstration and it does intend to continue to support them, the Committee has found it necessary to require of the Administration a plan for the continued development of such centers.

Section 305(b)—Requires the Secretary, not later than eighteen months after the date of enactment of this Act, to submit to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate a report setting forth (1) national standards for care provided by CMHCs, and (2) criteria for evaluation of CMHCs and the quality of services provided by them.

Since the Committee intends to continue and expand Federal support for CMHCs, it believes it to be appropriate to undertake the setting of standards and the development of evaluation criteria which will assure that this large investment of Federal funds is made in a program of uniformly high quality and efficiency.

TITLE IV—MIGRANT HEALTH

Section 401(a)—Rewrites section 319 of the PHS Act, which governs the migrant health program. New section 319 significantly expands the provisions of the existing section by defining a migrant health center, delineating the services to be provided, the basis for grants and certain conditions with regard to the operation of migrant health centers. The provisions of the new section 319 are set forth below.

New section 319(a) (1)—Defines a "migrant health center" as an entity which provides services to migratory agricultural workers and their families and seasonal agricultural workers performing similar work and their families (if the Secretary finds such service may contribute to the health of the migratory workers). The migrant health center is to be organized and operated as prescribed below.

Migrant health centers are to provide:

- (A) primary health services;
- (B) supplemental health services necessary for adequate support of primary health services (as appropriate for particular centers);

(C) referral to providers of supplemental health services and payment therefor (as appropriate and feasible) ;

(D) environmental health services including, as appropriate for particular centers, detection and alleviation of unhealthful conditions relating to water supply, sewage treatment, solid waste disposal, rodent and parasitic infestation, field sanitation, housing and other environmental factors related to health ;

(E) as may be appropriate accident prevention, including prevention of excessive pesticide exposure ;

(F) as may be appropriate, infectious and paracitic disease screening and control ; and

(G) information on the availability and proper use of health services.

New section 319(a)(2)—Defines “migratory agricultural worker” as an individual whose principal employment is employment in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purpose of such employment a temporary abode ;

New section 319(a)(3)—Defines “seasonal agricultural worker” as an individual whose principal employment is in agriculture on a seasonal basis and who is not migratory agricultural worker ;

New section 319(a)(4)—Defines “agriculture” as farming in all its branches, including tillage of the soil ; production, cultivating, growing, and harvesting of commodities grown on the land ; and practices performed in conjunction thereto by a farmer or on a farm.

New section 319(a)(5)—Defines “high impact area” as meaning a health service area or other area within a State which has not less than six thousand agricultural migratory workers residing within its boundaries for more than two months in any calendar year.

New section 319(a)(6)—Defines “primary health services” as meaning :

(A) services of physicians and, where feasible, services of physicians’ assistants and nurse clinicians ;

(B) diagnostic laboratory, and radiologic services ;

(C) preventive health services (including but not limited to children’s eye and ear examinations to determine the need for vision and hearing correction, parinatal services, well child services, and family planning services) ;

(D) emergency medical services ;

(E) transportation services as required for adequate patient care ; and

(F) preventive dental services ;

New section 319(a)(7)—Defines “supplemental health services” as meaning services which are not included as primary health services and which are :

(A) hospital services ;

(B) home health services ;

(C) extended care facilities services ;

(D) rehabilitation services (including physical therapy) and long-term physical medicine ;

- (E) mental health services;
- (F) Dental services;
- (G) vision services;
- (H) allied health services;
- (I) pharmaceutical services;
- (J) therapeutic radiologic services;
- (K) public health services (including nutrition, education, and social services;
- (L) health education services; and
- (M) services which promote and facilitate the optimal use of primary and supplemental health services.

New section 319(b)—Requires the Secretary to assign priority to high impact and other appropriate areas for the provision of support in such areas under this section. The Secretary is to assign the highest priority to areas in which reside the greatest number of migratory workers and members of their families for the longest period of time. The section additionally requires that no projects authorized under either section (c) or (d) of the new Act may be approved unless grants have been awarded to all approved applications under such subsections in areas with migratory agricultural workers.

New section 319(c)—Authorizes the Secretary (1) to make grants to public and nonprofit private entities to assist in the planning and development of migrant health centers which will serve migratory agricultural workers, seasonal agricultural workers and members of their families in high impact areas and (2) to make grants to or enter into contracts with public and nonprofit private entities for projects to plan and develop programs in areas in which no migrant health center exists and in which not more than 6,000 migratory agricultural workers and their families reside for more than two months. These contracts and grants for projects which will not become centers shall provide:

- (1) for the provision of emergency care to migratory and seasonal agricultural workers and their families;
- (2) for the provision of primary care (which may be different from primary health services, as defined, and is to be defined by regulations by the Secretary) for agricultural workers and their families;
- (3) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations to agricultural workers and their families; or
- (4) for activities which otherwise improve the health of agricultural migratory workers and their families.

This subsection provides that grants for planning and development of migrant health centers and projects may include the cost of the acquisition and modernization of existing buildings and the costs of providing training related to the management of migrant health center programs. Grants for planning and development are limited to two years.

New section 319(d)—Authorizes the Secretary to make grants to migrant health centers in high impact areas and not more than two grants to public and nonprofit entities which intend to become migrant health centers in high impact areas.

Grants and contracts are also authorized for the operation of programs in areas where no migrant health centers exist and in which not

more than 6,000 migratory agricultural workers and their families reside for more than two months for the provision of services identical to those authorized for planning and development projects under section 319(c).

Grants for operation of migrant health centers and for entities which intend to become migrant health centers may include the costs of acquiring and modernizing existing buildings, including the costs of amortizing the principal of, and paying the interest on loans. The cost of all three grants under this subsection may include the costs of providing training related to the provision of primary health service, supplemental health services and environmental health services, and to the management of migrant health center programs.

New section 319(e)—Authorizes the Secretary to enter into contracts with public and private entities to:

(1) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migrant labor camps and applicable Federal and State pesticide control standards; and

(2) conduct projects and studies to assist the several States in the assessment of problems related to camp and field sanitation, pesticide hazards, and other environmental health problems faced by migratory and seasonal agricultural workers.

New section 319(f)(1)—Provides that no grant may be made or contract entered into under new section 319 unless an application therefor has been submitted to and approved by the Secretary. Applications are to be submitted in such form and manner and contain such information as the Secretary prescribes. For projects involving construction, the application must contain site description, plans and specifications, and assurances that all laborers will be paid in accordance with the Davis-Bacon Act. The Secretary is not to approve an application for a grant under section 319(d)(1)(a) for a migrant health center unless he determines that the applicant is a migrant health center within the meaning of subsection (a) and:

(A) primary health services will be available and accessible and provide continuity of care;

(B) the center will have an ongoing quality assurance program and maintain confidentiality of records;

(C) the center will follow prescribed accounting procedures;

(D) the center will make arrangements for participation in the State Medicaid plan or has made reasonable efforts to do so;

(E) the center will make arrangements for collection from Medicaid, Medicare, and other public and private insurance participation;

(F) the center has prepared a service fee schedule and made reasonable attempts to collect fees;

(G) the center will have a governing board representative of those served by the center;

(H) the center has developed a plan and budget consistent with section 1861(z) of the Social Security Act and will collect and report such data as the Secretary may require;

(I) the center will periodically review its catchment area to assure availability of services, conformance with relevant boundaries, and elimination of barriers to access to services; and

(J) if it serves persons of limited English-speaking ability, the center will make provisions to overcome any language and cultural barriers to the delivery of health care and services.

New section 319(g)—Authorizes the Secretary either through the Department or by grants and contracts to provide all necessary technical and other nonfinancial assistance to any migrant health center or to any public or private nonprofit entity to assist it in developing plans for and in operating as a migrant health center, and in meeting the requirements of approval for the award of funds.

New section 319(h)—Authorizes appropriations for grants and contracts under the section 319 of \$4,000,000 for planning and development; \$30,000,000 for operating grants; and \$5,000,000 for hospitalization in connection with operating grants for fiscal 1976 and \$4,000,000, \$35,000,000 and \$5,000,000, respectively, for such grants for fiscal 1977. Requires that, of any funds appropriated under this authorization, an amount not exceeding the greater of 30 per centum of such funds or 90 per centum of the amount of grants made under this section for the preceding fiscal year for programs described in subsection (d) (1) (c) (which provides for migrant health programs other than migrant health centers) may be used for such grants and contracts in fiscal year 1976, and an amount not exceeding the greater of 25 per centum of such funds or 90 per centum of the amount of grants made under this section for the fiscal year ending June 30, 1975, may be used for such grants and contracts during fiscal year 1977. Of any funds appropriated under the authorization for operating grants, not more than 10 per centum are to be used for contracts under subsection 319(e) (which provides for contracts for the improvement of the healthfulness of the migrants' environment).

Section 401(b)—Adds to the PHS Act a new section 217(g) which requires the Secretary to appoint and organize a National Advisory Council on Migrant Health by October 1, 1975 to advise, consult with, and make recommendations to the Secretary regarding the organization, operation, selection, and funding of migrant health centers and other entities. The Council will consist of fifteen members, of whom twelve shall be members of the governing boards of migrant health centers, and at least nine shall be chosen from among these members of governing boards who are being served by such centers or grantees and who are familiar with the delivery of health care to migratory agricultural and seasonal agricultural workers.

Section 401(c)—Requires the Secretary of HEW to conduct or arrange for the conduct of a study of:

(1) the quality of housing which is available to agricultural migratory workers in the United States during the period of their employment in seasonal agricultural activities while away from their permanent abodes:

(2) the effect on the health of such workers of deficiencies in their housing conditions during such periods; and

(3) Federal, State, and local government standards respecting housing conditions for such workers during such period and the adequacy of the enforcement of such standards. In conducting or arranging for the conduct of this study the Secretary is to consult with the Secretary of Housing and Urban Development.

Requires that the study be completed and a report detailing the findings of it and the recommendations of the Secretary for Federal action

(including legislation) respecting such housing conditions be submitted to the Committee on Interstate and Foreign Commerce of the House of Representatives and the Committee on Labor and Public Welfare of the Senate within 18 months of the date of enactment of the first act making appropriations for such study.

TITLE V—COMMUNITY HEALTH CENTERS

Section 501(a)—Amends part C of title III of the PHS Act by adding section 329 a new section 330 which provides authority for the Secretary to assist community health centers (CHCs). The provisions of the new section are as follows:

COMMUNITY HEALTH CENTERS

New section 330(a)—Provides that for the purposes of the new section, the term “community health center” means an entity which either through its staff supporting resources or through contracts or cooperative arrangements with other public or private entities provides the following services:

- (i) primary health services;
- (ii) as may be appropriate for particular CHCs, supplemental health services as necessary for the adequate support of primary health services;
- (iii) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services;
- (iv) as may be appropriate for particular CHCs, environmental health services; and
- (v) information on the availability and proper use of health services

for all residents of the area it serves (referred to in this section as a “catchment area”).

New section 330(b)—For the purpose of the section 330 defines the following terms:

- (1) “primary health services” as meaning:
 - (A) services of physicians and, where feasible, services of physicians’ assistants and nurse clinicians;
 - (B) diagnostic laboratory and radiologic services;
 - (C) preventive health services (including, but not limited to, children’s eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well-child services, and family planning services);
 - (D) emergency medical services;
 - (E) transportation services as required for adequate patient care; and
 - (F) preventive dental services.
- (2) “supplemental health services” as meaning services which are not included as primary health services and which are:
 - (A) hospital services;
 - (B) home health services;
 - (C) extended care facility services;
 - (D) rehabilitative services (including physical therapy) and long-term physical medicine;

- (E) mental health services;
- (F) dental services;
- (G) vision services;
- (H) allied health services;
- (I) pharmaceutical services;
- (J) therapeutic radiologic services;
- (K) public health services (including nutrition education and social services);
- (L) health education services; and
- (M) services which promote and facilitate optimal use and the services referred to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a Community Health Center are of limited English-speaking ability, the services of outreach workers fluent in the language spoken by a predominant number of individuals.

(3) "medically underserved population as a population designated by the Secretary as an area with a shortage of personnel or a population having a shortage of services.

New Section 330(c)—Authorizes the Secretary to make grants to public and nonprofit private entities to assist them in planning and developing CHCs which will serve a medically underserved population. Grants may be made to include the costs of acquisition and modernization of buildings and must include (i) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services; (ii) the design of a community health center program for such population based on such assessment; (iii) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and (iv) initiation and encouragement of continuing community involvement in the development and operation of the project. No more than two grants may be made to a project for planning and development.

New Section 330(d)—Authorizes the Secretary to make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations, and grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but which have not met the application requirements for community health centers. The costs for which a grant may be made may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying interest on, loans) and the costs of providing training related to the provision of primary health services, supplemental health services and environmental health services, and to the management of community health center programs.

Not more than two grants may be made under this section to entities which have not met the application requirements for Community Health Centers.

New Section 330(e)—Provides that applications for assistance under subsection (e) must be submitted to the Secretary in the form and manner which he shall prescribe and that applications for costs of modernizing a building must contain site description, plans, and spec-

ifications and assurances that all laborers will be paid in accordance with the Davis-Bacon Act.

This subsection further provides that except for applications submitted under section 319(d)(1)(B), the Secretary may not approve an application for a grant for a CHC unless he determines that:

(A) primary health services of the center will be available and accessible and provide continuity of care;

(B) the center will have an ongoing quality assurance program and maintain confidentiality of records;

(C) the center will follow prescribed accounting procedures;

(D) the center will make arrangements for participation in the State Medicaid plan or has made reasonable efforts to seek such arrangements;

(E) the center will make arrangements for collection from Medicaid, Medicare, and other public and private insurance participation;

(F) the center has prepared a service fee schedule and made reasonable attempts to collect fees;

(G) the center will have a governing board representative of those served by the center;

(H) the center has developed a plan consistent with section 1844(z) of the Social Security Act and will collect and report such data as the Secretary may require;

New section 330(f)—Authorizes the Secretary, either through grant or contract, to provide all necessary technical or other nonfinancial assistance (including fiscal and program management, and training in such management) to entities to develop plans for, and operate as, CHCs.

New section 330(g)—Authorizes appropriations for the purposes of payments under grants under section 330(c) in the amounts of \$220 million for fiscal 1976 and \$240 million for 1977, of which \$5,000,000 for each year is authorized for planning and development grants.

Section 501(b)—Repeals section 314(e) of the PHS Act. Section 314(e) of the PHS Act is the general authority under which the Secretary is now supporting community health centers.

TITLE VI—MISCELLANEOUS

DISEASES BORNE BY RODENTS

Section 601(a)—Amends section 317(h)(1) of the PHS Act by expanding the definition of State communicable disease control programs eligible for Federal assistance to include "diseases borne by rodents."

Section 601(b)—Amends section 317(d)(3) of such Act to increase, by reason of the addition of "diseases borne by rodents" to communicable disease control programs, the authorization level of this section by \$20 million for fiscal year 1976.

HOME HEALTH SERVICES

Section 602(a)(1)—Authorizes the Secretary of Health, Education, and Welfare to make demonstration grants to meet the initial costs of establishing and operating (including the costs of compensating

professional and paraprofessional personnel) public and nonprofit private agencies which will provide home health services in areas where such services are not otherwise available. Specifies that grants may also be used to expand the services available through existing agencies. Further provides that agencies assisted and the services provided must meet the Medicare definitions of a home health agency (section 1861(o) of the Social Security Act) and home health services (section 1861(m) of such Act.).

Section 602(a)(2)—Requires the Secretary in making grants to consider the relative needs of the States for home health services and to give preference to areas within States which have a high percentage of persons who are elderly, medically indigent, or both.

Section 602(a)(3)—Requires that grant applications be submitted in the form and contain such information as the Secretary prescribes in regulations.

Section 602(a)(4)—Provides that payment of grants may be made in advance, by way of reimbursement, or in installments, as the Secretary may determine.

Section 602(a)(5)—Authorizes for such demonstration grants appropriations of \$8 million for fiscal year 1976.

Section 602(b)(1)—Authorizes the Secretary to make grants to public and nonprofit private entities to assist them in demonstrating the training of professional and paraprofessional personnel to provide home health services (as defined in section 1861(m) of the Social Security Act).

Section 602(b)(2)—Requires that applications for grants under this subsection be submitted in the form and contain such information as the Secretary prescribes in regulations.

Section 602(b)(3)—Provides that payment of grants may be made in advance, by way of reimbursement, or in installments, as the Secretary may determine.

Section 602(b)(4)—Authorizes for grants under this subsection appropriations of \$2 million for fiscal year 1976.

COMMITTEE ON MENTAL HEALTH AND ILLNESS OF THE ELDERLY

Section 603(a)—Requires the Secretary of Health, Education, and Welfare to appoint a Committee on Mental Health and Illness of the Elderly to make a study of and provide recommendations respecting—

(1) the future needs for mental health facilities, manpower, research, and training to meet the mental health care needs of elderly persons,

(2) the appropriate care of elderly persons who are in mental institutions or who have been discharged from such institutions, and

(3) proposals for implementing the recommendations of the 1971 White House Conference on Aging respecting the mental health of the elderly.

Section 603(b)—Requires the Secretary, within one year from the date of enactment of this Act, to report to the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House the findings of this study and the Committee's recommendations.

Section 603(c) (1)—Requires that the Committee be comprised of nine members appointed by the Secretary. Provides that the Committee include at least one member from each of the fields of psychology, psychiatry, social science, social work, and nursing. Further requires that each member be exceptionally qualified, as the result of training, experience, or attainments, to assist in carrying out the functions of the Committee.

Section 603(c) (2)—Provides that members of the Committee shall receive compensation at a rate to be fixed by the Secretary, but not exceeding the daily equivalent of the annual rate of basic pay in effect for grade GS-18 for the General Schedule, for each day (including traveltime) during which they are engaged in the actual performance of duties vested in the Committee. Further provides that while away from their homes or regular places of business in the performance of services for the Committee, members shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5730(b) of title 5 of the U.S.C.

Section 603(d)—Provides that the Committee shall cease to exist thirty days after the submission of its report.

COMMISSION FOR THE CONTROL OF EPILEPSY

Section 604(a)—Requires the Secretary of Health, Education, and Welfare to establish a temporary commission to be known as the Commission for the Control of Epilepsy and Its Consequences.

Section 604(b)—Specifies that the Commission shall—

(1) make a comprehensive study of the state of the art of medical and social management of the epilepsies in the United States;

(2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with epilepsy;

(3) develop a comprehensive national plan for the control of epilepsy and its consequences based on the most thorough, complete, and accurate data and information available on the disorder; and

(4) transmit to the President and the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House, not later than one year after the date of enactment of this Act, a report detailing the findings and conclusions of the Commission, together with its recommendations for legislation and appropriations.

Section 604(c) (1)—Provides that the Commission be comprised of nine members appointed by the Secretary. Specifies that members include consumers of health services and that members be especially qualified, by reason of experience or training in the medical, social, or educational aspects of epilepsies, to serve on the Commission.

Section 604(c) (2)—Provides that the Secretary designate one of the members of the Commission to serve as Chairman and one to serve as Vice Chairman. Specifies that vacancies be filled in the same manner in which the original appointments were made. Further provides that any vacancy in the Commission shall not affect its powers.

Section 604(c) (3)—Provides that any member of the Commission who is otherwise employed by the Federal Government shall serve without compensation in addition to that received in his regular employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by him in the performance of his duties on the Commission.

Section 604(c) (4)—Provides that members of the Commission, other than those referred to in the preceding paragraph, shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence, in the manner as persons employed intermittently in the government service are allowed expenses under section 5703 of title 5, U.S.C.

Section 604(d)—Provides that the Commission shall cease to exist thirty days after the submission of its final report.

COMMISSION FOR THE CONTROL OF HUNTINGTON'S DISEASE

Section 605(a)—Requires the Secretary of Health, Education, and Welfare to establish a temporary commission to be known as the Commission for the Control of Huntington's Disease and Its Consequences.

Section 605(b)—Specifies that the Commission shall—

(1) make a comprehensive study of the state of the art of medical and social management of Huntington's disease in the United States;

(2) investigate and make recommendations concerning the proper roles of Federal and State governments and national and local public and private agencies in research, prevention, identification, treatment, and rehabilitation of persons with Huntington's disease;

(3) develop a comprehensive national plan for the control of Huntington's disease and its consequences, based on the most thorough, complete, and accurate data and information available on the disorder; and

(4) transmit to the President and the Committee on Labor and Public Welfare of the Senate and the Committee on Interstate and Foreign Commerce of the House, not later than one year after the date of enactment of this Act, a report detailing the findings and conclusions of the Commission, together with its recommendations for legislation and appropriations.

Section 605(c) (1)—Provides that the Commission be comprised of nine members appointed by the Secretary. Specifies that members include consumers of health services and that members be especially qualified, by reason of experience or training in the medical, social, or educational aspects of Huntington's disease, to serve on the Commission.

Section 605(c) (2)—Provides that the Secretary designate one of the members of the Commission to serve as chairman and one to serve as Vice Chairman. Specifies that vacancies shall be filled in the same

manner in which the original appointments were made. Further provides that any vacancy in the Commission shall not affect its powers.

Section 605(c) (3)—Provides that any member of the Commission who is otherwise employed by the Federal Government shall serve without compensation in addition to that received in his regular employment, but shall be entitled to reimbursement for travel, subsistence, and other necessary expenses incurred by him in the performance of his duties on the Commission.

Section 605(c) (5)—Provides that members of the Commission other than those referred to in the preceding paragraph, shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, U.S.C.

Section 605(d)—Provides that the Commission shall cease to exist thirty days after the submission of its final report.

HEMOPHILIA PROGRAMS

Section 606—Amends Title XI of the Public Health Service Act by adding after part C the following new part:

Part D—Hemophilia Programs

TREATMENT CENTERS

New section 1131(a)—Authorizes the Secretary to make grants to and enter into contracts with public and nonprofit private entities for projects to establish comprehensive hemophilia diagnostic and treatment centers. Requires a center established with such assistance to provide—

(1) access to the services of the center for all individuals suffering from hemophilia who reside within the geographic area served by the center;

(2) programs for the training of professional and paraprofessional personnel in hemophilia research, diagnosis, and treatment;

(3) a program for the diagnosis and treatment of individuals suffering from hemophilia who are being treated on an outpatient basis;

(4) a program for association with providers of health care who are treating individuals suffering from hemophilia in areas not conveniently served directly by the center but who are more conveniently (as determined by the Secretary) served by it than by the next geographically closest center;

(5) programs of social and vocational counseling for individuals suffering from hemophilia; and

(6) individualized written comprehensive care programs for each individual treated by or in association with the center.

New section 1131(b)—Provides that no grant or contract may be made for the establishment of a hemophilia diagnostic and treat-

ment center unless an application has been submitted to the Secretary in such form and manner and containing such information as he requires, and has been approved by him.

New section 1131(c)—Requires that an application for the establishment of a hemophilia center under subsection (a) contain assurances satisfactory to the Secretary that the applicant will serve the maximum number of individuals that is available and potential resources will enable it to serve effectively.

New section 1131(d)—Requires the Secretary, in considering applications for grants and contracts for projects to establish hemophilia diagnostic and treatment centers, to—

- (1) take into account the number of persons to be served by the programs to be supported by such centers and the extent to which rapid and effective use will be made of funds provided by such grants and contracts, and

- (2) give priority to projects for centers which will operate in areas which the Secretary determines have the greatest number of persons in need of the services provided by such centers.

New section 1131(e)—Provides that contracts may be entered into under the authority provided above in subsection (a) without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

New section 1131(f)—Authorizes for grants and contracts for the establishment of comprehensive hemophilia diagnostic and treatment centers appropriations of \$3 million for fiscal year 1976 and \$4 million for fiscal year 1977.

BLOOD SEPARATION CENTERS

New section 1132(a)—Authorizes the Secretary to make grants to and enter into contracts with public and nonprofit private entities for projects to develop and expand, within existing facilities, blood-separation centers to separate and make available for distribution blood components to providers of blood services and manufacturers of blood fractions. Defines, for the purposes of this section—

- (1) the term “blood components” as those constituents of whole blood which are used for therapy and which are obtained by physical separation processes which result in licensed products such as red blood cells, platelets, white blood cells, AHF-rich plasma, fresh-frozen plasma, cryoprecipitate, and single unit plasma for infusion; and

- (2) the term “blood fractions” as those constituents of plasma which are used for therapy and which are obtained by licensed fractionation processes presently used in manufacturing which result in licensed products such as normal serum albumin, plasma, protein fraction, prothrombin complex, fibrinogen, AFH concentrate, immune serum globulin, and hyperimmune globulins.

New section 1132(b)—Authorizes the Secretary, in the event that he finds that there is an insufficient supply of blood fractions available to meet the needs for treatment of persons suffering from hemophilia, and that public and other nonprofit private centers already engaged in the production of blood fractions could alleviate such insufficiency with assistance under this subsection, to make grants not to exceed \$500,000 to such centers for the purposes of alleviating the insufficiency.

New section 1132(c)—Provides that no grant or contract may be made under subsections (a) and (b) above unless an application has been submitted to the Secretary in such form and manner and containing such information as he requires, and has been approved by him.

New section 1132(d)—Provides that contracts may be entered into under the authority provided above in subsection (a) without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C.).

New section 1132(e)—Authorizes for grants and contracts under subsections (a) and (b) appropriations of \$4 million for fiscal year 1976 and \$5 million for fiscal year 1977.

TITLE VII—EXTENSION OF CURRENT AUTHORITIES THROUGH FISCAL YEAR 1975

Section 701(a)—Amends section 314(d) of the PHS Act, "Grants for Comprehensive Public Health Services," by authorizing for fiscal year 1975 appropriations at levels equal to those authorized for fiscal year 1974.

Section 701(b)—Amends section 314(e) of the PHS Act, "Projects Grants for Health Services Development," by authorizing for fiscal year 1975 appropriations at levels equal to those authorized for fiscal year 1974.

Section 701(c)—Amends section 319 of the PHS Act, "Health Services for Domestic Agricultural Migrants," by authorizing for fiscal year 1975 appropriations at levels equal to those authorized for fiscal year 1974.

Section 701(d)—Amends relevant sections of title X of the PHS Act, "Population Research and Voluntary Family Planning Programs," by authorizing for fiscal year 1975 appropriations at levels equal to those authorized for fiscal year 1974.

Section 701(e)—Amends relevant sections of the Community Mental Health Centers Act by authorizing for fiscal year 1975 appropriations at levels equal to those authorized for fiscal year 1974.

AGENCY REPORTS

Agency reports were not requested or received on H.R. 4925, or its similar predecessor, H.R. 2954, because they are essentially identical to H.R. 14214 of the 93d Congress which was vetoed by President Ford after adjournment in December. Reproduced below for the use and interest of the Members are both the President's Memorandum of Disapproval on H.R. 14214 and a letter from Secretary of Health, Education and Welfare Caspar W. Weinberger to Chairman Harley O. Staggers on H.R. 2954.

OFFICE OF THE WHITE HOUSE SECRETARY,
December 23, 1974.

For immediate release:

THE WHITE HOUSE

MEMORANDUM OF DISAPPROVAL

I have withheld my approval from H.R. 14214, the "Health Revenue Sharing and Health Services Act of 1974."

H.R. 14214 conflicts with my strong commitment to the American taxpayers to hold Federal spending to essential purposes. The bill authorizes appropriations of more than \$1 billion over my recommendations and I can not, in good conscience, approve it. These appropriation authorizations are almost double the funding levels I have recommended for Fiscal Year 1975 and almost triple the levels I believe would be appropriate for 1976.

As part of my effort to see that the burden upon our taxpayers does not increase, I requested the Congress last month to exercise restraint in expanding existing Federal responsibilities, and to resist adding new Federal programs to our already overloaded and limited Federal resources. These recommendations reflect my concern with both the need to hold down the Federal budget and the need to limit the Federal role to those activities which can make the most necessary and significant contributions.

In H.R. 14214, the Congress not only excessively increased authorizations for existing programs but also created several new ones that would result in a unjustified expenditure of Federal taxpayers' funds. Although the purposes of many of the programs authorized in this bill are certainly worthy, I just cannot approve this legislation because of its effect upon the economy through increased unwarranted Federal spending.

Finally, it should be pointed out that the Federal Government will spend almost \$20 billion in 1975 through Medicare and Medicaid for the financing of health services for priority recipients—aged and low-income persons. These services are provided on the basis of national eligibility standards in Medicare and State eligibility standards in

Medicaid and therefore are available to individuals in a more equitable and less restrictive manner than many of the programs authorized in H.R. 14214.

GERALD R. FORD.

THE WHITE HOUSE,
December 21, 1974.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 5, 1975.

HON. HARLEY O. STAGGERS,
Chairman, Committee on Interstate and Foreign Commerce, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: We understand that the Interstate and Foreign Commerce Committee intends to consider this week H.R. 2954, Health Revenue Sharing and Health Services Act, as reported by the Subcommittee on Public Health and Environment. I enclose a copy of the President's Memorandum of Disapproval of H.R. 14214, a bill very similar to the one before you for consideration, and a copy of my testimony before the Subcommittee which contains our objections to the bill. Moreover, I would like to reiterate again the Department's strong opposition to this legislation.

Although some changes have been made at the Subcommittee level, we do not believe that significant progress has been made toward overcoming any of the President's objections. The Administration has submitted its proposal in draft legislation entitled the Health Services Amendments of 1975. Title I of that bill would consolidate most of the project grant structures proposed in H.R. 2954. I recommend enactment of this legislation.

The Subcommittee on Public Health and Environment did attempt to lower authorizations, and this is a step in the right direction. But the authorizations still are far in excess of the President's budget and, therefore, remain objectionable to the Administration. The total authorizations for this three-year bill are \$2.3 billion, approximately \$900 million over the President's budget for FY 75, FY 76 and an estimate for FY 77 at the same level as in FY 76.

Moreover, the Department has consistently also expressed its opposition to this bill for programmatic reasons. Since the bill would extend and authorize a number of new categorical programs, the Department continues to oppose this legislation on both programmatic and fiscal grounds.

We are advised by the Office of Management and Budget that there is no objection to the submission of this report from the standpoint of the Administration's program, and that enactment of H.R. 2954 would not be in accord with the program of the President.

Sincerely,

CASPAR W. WEINBERGER, *Secretary.*

Enclosures.

INFLATION IMPACT STATEMENT

The Committee is unaware of any inflationary impact that H.R. 4925 would have on the economy if this legislation were enacted. The legislation proposes a revision and extension of a number of existing authorities for fiscal years 1976 and 1977. Total authorizations for programs extended by this bill would actually be reduced by \$8.3 million for fiscal year 1976, when these are compared with authorization levels for 1974, and increased by only \$53 million for fiscal year 1977. Programs for which authorizations would be initiated by this legislation would add only \$24 million to the totals for existing programs in fiscal 1976 and \$16 million in fiscal 1977. In addition, it should be noted that total authorizations proposed by H.R. 4925 for fiscal year 1976 represent less than 0.20 percent of all Federal expenditures proposed by the President in his budget for fiscal year 1976.

The Committee also notes that while the inflationary impact of this bill is negligible, the effect of inflation on the various programs has been and continues to be substantial. Between April 1974, when price controls were lifted, and February 1975, medical care prices rose at an annualized rate of 14.5 percent. This rate affects the costs of operation of the various programs by increasing the prices of medical supplies and equipment, the costs of contracted provider services and the salaries of professional staff if these individuals are to be retained. If the various programs are to continue to fulfill their clearly vital functions of providing health care services to segments of the population with special needs, and screening, immunization, and other services at the State and local levels, a revitalized and unequivocal Federal commitment is required. With medical care prices escalating as rapidly as they have for the past ten months, this commitment becomes absolutely imperative if the comprehensive nature of the services being provided is not to be jeopardized and if these programs are not to be compelled to reduce the number of services they provide the communities they serve.

PROGRAM OVERSIGHT

The Committee's principal oversight activities with respect to this program have been conducted by the Subcommittee on Health and the Environment in connection with its consideration of the legislative authority. Oversight hearings on the Program and several other Federal health programs were conducted by the Subcommittee in January of 1973, and legislative hearings were held in February of 1974, and again in February of 1975. The Subcommittee's findings are discussed in the report in sections entitled "Background" as the proposed legislation is designed to respond to the Subcommittee's findings.

The Committee has not received oversight reports from either its own Subcommittee on Investigations and Oversight or the Committee on Government Operations.

CHARGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in *roman*) :

PUBLIC HEALTH SERVICE ACT ¹

* * * * *

TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * *

PART B—FEDERAL-STATE COOPERATION

GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

Grants to States for Comprehensive State Health Planning

SEC. 314. (a) * * *

* * * * *

¹ The following text shows changes in existing law made by the bill which extend the current authorities through fiscal year 1975. Such changes shall take effect upon enactment of the bill.

Grants for Comprehensive Public Health Services

(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$70,000,000 for the fiscal year ending June 30, 1968, \$90,000,000 for the fiscal year ending June 30, 1969, \$100,000,000 for the fiscal year ending June 30, 1970, \$130,000,000 for the fiscal year ending June 30, 1971, \$145,000,000 for the fiscal year ending June 30, 1972, \$165,000,000 for the fiscal year ending June 30, 1973, and \$90,000,000 each for the fiscal [year] years ending June 30, 1974, and June 30, 1975, to enable the Secretary to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for provisions of public health services.

* * * * *

Project Grants for Health Services Development

(e) There are authorized to be appropriated \$90,000,000 for the fiscal year ending June 30, 1968, \$95,000,000 for the fiscal year ending June 30, 1969, \$80,000,000 for the fiscal year ending June 30, 1970, \$109,500,000 for the fiscal year ending June 30, 1971, \$135,000,000 for the fiscal year ending June 30, 1972, and \$157,000,000 for the fiscal year ending June 30, 1973, and \$230,700,000 each for the fiscal [year] years ending June 30, 1974, and June 30, 1975, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements and amortization of loans on facilities acquired from the Office of Economic Opportunity or construction in connection with any program or project transferred from the Office of Economic Opportunity) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Any grant made under this subsection may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services assisted under such grant will be provided in accordance with such plans as have been developed pursuant to subsection (a). No grant may be made under this subsection for the fiscal year ending June 30, [1974], 1975, to cover the cost of services described in clause (1) or (2) of the first sentence if a grant or contract to cover the cost of such services may be made or entered into from funds authorized to be appropriated for such fiscal year under an authorization of appropriations in any provision of this Act (other than this subsection) amended by [title I of the Health Programs Extension Act of 1973] title VII of the Health Revenue Sharing and Health Services Act of 1975. No funds appropriated pursuant to the authorization of this

subsection shall be available for lead based paint poisoning control of the type authorized under the Lead Based Paint Poisoning Prevention Act of (84 Stat. 2078)."

* * * * *

HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

SEC. 319. There are hereby authorized to be appropriated not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 each for the fiscal year ending June 30, 1968, and the next fiscal year, \$15,000,000 for the fiscal year ending June 30, 1970, \$20,000,000 for the fiscal year ending June 30, 1971, \$25,000,000 for the fiscal year ending June 30, 1972, \$30,000,000 for the fiscal year ending June 30, 1973, and \$26,750,000 each for the fiscal [year] years ending June 30, 1974, and June 30, 1975, to enable the Secretary (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons (including allied health professions personnel) to provide services in the establishing and operating of such clinics, and (ii) special projects to improve and provide a continuity in health services for and to improve the health conditions of domestic agricultural migratory workers and their families, including necessary hospital care, and including training persons (including allied health professions personnel) to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The Secretary may also use funds appropriated under this section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families. For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs.

* * * * *

TITLE X—POPULATION RESEARCH AND VOLUNTARY
FAMILY PLANNING PROGRAMS

PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES

SEC. 1001. (a) * * *

* * * * *

(c) For the purpose of making grants and contracts under this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971; \$60,000,000 for the fiscal year ending June 30, 1972; \$111,500,000 for the fiscal year ending June 30, 1973, and \$111,500,000 *each* for the fiscal [year] *years* ending June 30, 1974, and June 30, 1975.

* * * * *

TRAINING GRANTS AND CONTRACTS

SEC. 1003. (a) * * *

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$2,000,000 for the fiscal year ending June 30, 1971; \$3,000,000 for the fiscal year ending June 30, 1972; \$4,000,000 for the fiscal year ending June 30, 1973, and \$3,000,000 *each* for the fiscal [year] *years* ending June 30, 1974, and June 30, 1975.

RESEARCH GRANTS AND CONTRACTS

SEC. 1004. (a) * * *

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971; \$50,000,000 for the fiscal year ending June 30, 1972; \$65,000,000 for the fiscal year ending June 30, 1973; and \$2,615,000 *each* for the fiscal [year] *years* ending June 30 1974, and June 30, 1975.

INFORMATIONAL AND EDUCATIONAL MATERIALS

SEC. 1005. (a) * * *

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$750,000 for the fiscal year ending June 30, 1971; \$1,000,000 for the fiscal year ending June 30, 1972; \$1,250,000 for the fiscal year ending June 30, 1973; and \$909,000 *each* for the fiscal [year] ending June 30, 1974, and June 30, 1975.

COMMUNITY MENTAL HEALTH CENTERS ACT¹

TITLE II—COMMUNITY MENTAL HEALTH CENTERS

SHORT TITLE

SEC. 200. This title may be cited as the "Community Mental Health Centers Act".

PART A—GRANTS FOR CONSTRUCTION

AUTHORIZATION OF APPROPRIATIONS

SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, \$35,000,000 for the fiscal year ending June 30, 1965, \$50,000,000 for the fiscal year ending June 30, 1966, \$65,000,000 for the fiscal year ending June 30, 1967, \$50,000,000 for the fiscal year ending June 30, 1968, \$60,000,000 for the fiscal year ending June 30, 1969, \$70,000,000 for the fiscal year ending June 30, 1970, \$80,000,000 for the fiscal year ending June 30, 1971, \$90,000,000 for the fiscal year ending June 30, 1972, \$100,000,000 for the fiscal year ending June 30, 1973, and \$20,000,000 *each* for the fiscal [year] years ending June 30, 1974, and June 30, 1975.

* * * * *

NONDUPLICATION OF GRANTS

SEC. 207. No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the fiscal years in the period beginning July 1, 1964, and ending June 30, [1974] 1975, for construction of any facility described in this title, unless the Secretary determines that funds are not available, under this title to make a grant for the construction of such facility.

* * * * *

APPLICATIONS AND CONDITIONS FOR APPROVAL

SEC. 221. (a) * * *

(b) No grant may be made under this part after June 30, [1974] 1975, with respect to any community mental health center or with respect to any type of service provided by such a center unless a grant

¹ The following text shows changes in existing law made by the bill which extend the current authorities through fiscal year 1975. Such changes shall take effect upon enactment of the bill.

with respect thereto was made under this part prior to July 1, [1974] 1975.

* * * * *

AUTHORIZATION OF APPROPRIATIONS

SEC. 224. (a) There are hereby authorized to be appropriated \$19,500,000 for the fiscal year ending June 30, 1966, \$24,000,000 for the fiscal year ending June 30, 1967, \$30,000,000 for the fiscal year ending June 30, 1968, \$26,000,000 for the fiscal year ending June 30, 1969, \$32,000,000 for the fiscal year ending June 30, 1970, \$45,000,000 for the fiscal year ending June 30, 1971, \$50,000,000 for the fiscal year ending June 30, 1972, \$60,000,000 for the fiscal year ending June 30, 1973, and \$49,131,000 *each* for the fiscal [year] *years* ending June 30, 1974, and June 30, 1975, to enable the Secretary to make initial grants to community mental health centers under the provisions of this part. For the fiscal year ending June 30, 1967, and each of the fourteen succeeding years, there are hereby authorized to be appropriated such sums as may be necessary to make grants to such centers which have previously received a grant under this part and are eligible for such a grant for the year for which sums are being appropriated under this sentence.

* * * * *

DIRECT GRANTS FOR SPECIAL PROJECTS

SEC. 246. The Secretary is authorized during the period beginning July 1, 1970, and ending June 30, [1974] 1975 to make grants to any public or nonprofit private agency or organization to cover part or all of the cost of (1) developing specialized training programs or materials relating to the provision of public health services for the prevention or treatment of alcoholism, or developing in-service training or short-term or refresher courses with respect to the provision of such services; (2) training personnel to operate, supervise, and administer such services; (3) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs; and (4) programs for treatment and rehabilitation of alcoholics which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such alcoholics.

GRANTS AND CONTRACTS FOR THE PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM

SEC. 247. (a) * * *

* * * * *

(d) To carry out the purposes of this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971, \$40,000,000 for the fiscal year ending June 30, 1972, and \$50,-

000,000 for each of the fiscal years ending June 30, 1973, [and] June 30, 1974, and June 30, 1975.

* * * * *

DIRECT GRANTS FOR SPECIAL PROJECTS

SEC. 252. The Secretary is authorized, during the period beginning July 1, 1968, and ending with the close of June 30, [1974] 1975, to make grants to any public or nonprofit private agencies and organizations to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of narcotic addiction, drug abuse, and drug dependence or developing in-service training or short-term or refresher courses with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; (C) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of narcotic addiction, drug abuse, and drug dependence within the several States with a view to determining ways and means of improving, extending, and expanding such programs; and (D) programs for treatment and rehabilitation of narcotic addicts and other persons with drug abuse and drug dependence problems which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such narcotic addicts and other persons with drug abuse and drug dependence problems.

DRUG ABUSE EDUCATION

SEC. 253. (a) * * *

* * * * *

(d) To carry out the purposes of this section, there are authorized to be appropriated \$3,000,000 for the fiscal year ending June 30, 1971, \$12,000,000 for the fiscal year ending June 30, 1972, \$14,000,000 for the fiscal year ending June 30, 1973, and \$1,700,000 *each* for the fiscal [year] years ending June 30, 1974, and June 30, 1975.

* * * * *

SPECIAL PROJECTS FOR NARCOTIC ADDICTS AND DRUG DEPENDENT PERSONS

SEC. 256. (a) * * *

* * * * *

(e) There are authorized to be appropriated to carry out this section not to exceed \$20,000,000 for the fiscal year ending June 30, 1971; \$30,000,000 for the fiscal year ending June 30, 1972; \$60,000,000 for the fiscal year ending June 30, 1973; and \$60,000,000 ending June 30, 1974 *each* for the fiscal [year] years ending June 30, 1974, and June 30, 1975.

* * * * *

PART E—GENERAL PROVISIONS

AUTHORIZATION OF APPROPRIATIONS FOR REHABILITATION OF ALCOHOLICS,
NARCOTIC ADDICTS, AND OTHER PERSONS WITH DRUG ABUSE AND DRUG
DEPENDENCE PROBLEMS

SEC. 261. (a) There are authorized to be appropriated \$15,000,000 for the fiscal year ending June 30, 1969, \$15,000,000 for the fiscal year ending June 30, 1970, \$40,000,000 for the fiscal year ending June 30, 1971, \$60,000,000 for the fiscal year ending June 30, 1972, \$80,000,000 for the fiscal year ending June 30, 1973, and \$36,774,000 *each* for the fiscal [year] *years* ending June 30, 1974, *and June 30, 1975*, for project grants for construction and staffing of facilities for the prevention and treatment of alcoholism under part C or the prevention and treatment of narcotic addiction, drug abuse, and drug dependence under part D and for grants under section 252 and section 246. Sums so appropriated for any fiscal year shall remain available for obligation until the close of the next fiscal year.

(b) There are also authorized to be appropriated for the fiscal year ending June 30, 1971, and each of the next ten fiscal years such sums as may be necessary to continue to make grants for staffing with respect to any project under part C or D for which a staffing grant was made from appropriations under subsection (a) of this section for any fiscal year ending before July 1, [1974.] 1975.

PART F—MENTAL HEALTH OF CHILDREN

GRANTS FOR TREATMENT FACILITIES

SEC. 271. (a) * * * *

* * * *

(d) (1) There are authorized to be appropriated \$12,000,000 for the fiscal year ending June 30, 1971, \$20,000,000 for the fiscal year ending June 30, 1972, and \$30,000,000 for the fiscal year ending June 30, 1973, and \$16,515,000 *each* for the fiscal [year] *years* ending June 30, 1974, *and June 30, 1975*, for grants under this part for construction and for initial grants under this part for compensation of professional and technical personnel, and for training and evaluation grants under section 272.

(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1972, and each of the next nine fiscal years such sums as may be necessary to continue to make grants with respect to any project under this part for which an initial staffing grant was made from appropriations under paragraph (1) for any fiscal year ending before July 1, [1974.] 1975.

PUBLIC HEALTH SERVICE ACT¹

TITLE II—ADMINISTRATION

NATIONAL ADVISORY COUNCILS

SEC. 217. (a)

have been active in the areas of drug abuse prevention, treatment, rehabilitation, training, or research.

(2) The Council shall advise, consult with, and make recommendations to, the Secretary

(A) concerning matters relating to the activities and functions of the Secretary in the field of drug abuse, including, but not limited to, the development of new programs and priorities, the efficient administration of programs, and the supplying of needed scientific and statistical data and program information to professionals, paraprofessionals, and the general public; and

(B) concerning policies and priorities respecting grants and contracts in the field of drug abuse.

² (f) (1) There shall be established a National Advisory Council for the Protection of Subjects of Biomedical and Behavioral Research (hereinafter in this subsection referred to as the "Council") which shall consist of the Secretary who shall be Chairman and not less than seven nor more than fifteen other members who shall be appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The Secretary shall select members of the Council from individuals distinguished in the fields of medicine, law, ethics, theology, the biological, physical, behavioral and social sciences, philosophy, humanities, health administration, government, and public affairs; but three (and not more than three) of the members of the Council shall be individuals who are or who have been engaged in biomedical or behavioral research involving human subjects. No individual who was appointed to be a member of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research (established under title II of the National Research Act) may be appointed to be a member

¹ The following text shows further changes in existing law which shall take effect on July 1, 1975 (unless otherwise indicated), after the proposed changes in the preceding text have already become effective. The existing law shown in roman in the following text incorporates the changes proposed by the preceding text.

² This subsection is effective July 1, 1976 (P.L. 93-248, sec. 217).

of the Council. The appointed members of the Council shall have terms of office for four years, except that for the purpose of staggering the expiration of the terms of office of the Council members, the Secretary shall, at the time of appointment, designate a term of office of less than four years for members first appointed to the Council.

(2) The Council shall—

(A) advise, consult with, and make recommendations to, the Secretary concerning all matters pertaining to the protection of human subjects of biomedical and behavioral research;

(B) review policies, regulations, and other requirements of the Secretary governing such research to determine the extent to which such policies, regulations, and requirements require and are effective in requiring observance in such research of the basic ethical principles which should underlie the conduct of such research and, to the extent such policies, regulations, or requirements do not require or are not effective in requiring observance of such principles, make recommendations to the Secretary respecting appropriate revision of such policies, regulations, or requirements; and

(C) review periodically changes in the scope, purpose, and types of biomedical and behavioral research being conducted and the impact such changes have on the policies, regulations, and other requirements of the Secretary for the protection of human subjects of such research.

(3) The Council may disseminate to the public such information, recommendations, and other matters relating to its functions as it deems appropriate.

(4) Section 14 of the Federal Advisory Committee Act shall not apply with respect to the Council.”

(g) (1) Not later than October 1, 1975, the Secretary shall appoint and organize a National Advisory Council on Migrant Health (hereinafter in this subsection referred to as the “Council”) which shall advise, consult with, and make recommendations to, the Secretary on matters concerning the organization, operation, selection, and funding of migrant health centers and other entities under grants and contracts under section 319.

(2) The Council shall consist of fifteen members, at least twelve of whom shall be members of the governing boards of migrant health centers or other entities assisted under section 319. Of such twelve members who are members of such governing boards, at least nine shall be chosen from among those members of such governing boards who are being served by such centers or grantees and who are familiar with the delivery of health care to migratory agricultural workers and seasonal agricultural workers. The remaining three Council members shall be individuals qualified by training and experience in the medical sciences or in the administration of health programs.

(3) Each member of the Council shall hold office for a term of four years, except that (A) any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term; and (B) the terms of the members first taking office after the date of enactment of this subsection shall expire as follows: four shall expire four years

after such date, four shall expire three years after such date, four shall expire two years after such date, and three shall expire one year after such date, as designated by the Secretary at the time of appointment.

(4) Section 14(a) of the Federal Advisory Committee Act shall not apply to the Council.

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TITLE III—GENERAL POWERS AND DUTIES OF PUBLIC HEALTH SERVICE

* * * * *

PART B—FEDERAL-STATE COOPERATION

* * * * *

GRANTS FOR COMPREHENSIVE HEALTH PLANNING AND PUBLIC HEALTH SERVICES

Grants to States for Comprehensive State Health Planning

SEC. 314. (a) (1) * * *

* * * * *

Grants for Comprehensive Public Health Services

[(d) (1) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated \$70,000,000 for the fiscal year ending June 30, 1968, \$90,000,000 for the fiscal year ending June 30, 1969, \$100,000,000 for the fiscal year ending June 30, 1970, \$130,000,000 for the fiscal year ending June 30, 1971, \$145,000,000 for the fiscal year ending June 30, 1972, \$165,000,000 for the fiscal year ending June 30, 1973, and \$90,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, to enable the Secretary to make grants to State health or mental health authorities to assist the States in establishing and maintaining adequate public health services, including the training of personnel for State and local health work. The sums so appropriated shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for provision of public health services.

[(2) STATE PLANS FOR PROVISION OF PUBLIC HEALTH SERVICES.—In order to be approved under this subsection, a State plan for provision of public health services must—

[(A) provide for administration or supervision of administration by the State health authority or, with respect to mental health services, the State mental health authority;

[(B) set forth the policies and procedures to be followed in the expenditure of the funds paid under this subsection;

[(C) contain or be supported by assurances satisfactory to the Secretary that (i) the funds paid to the State under this subsection will be used to make a significant contribution toward pro-

viding and strengthening public health services in the various political subdivisions in order to improve the health of the people; (ii) such funds will be made available to other public or nonprofit private agencies, institutions, and organizations, in accordance with criteria which the Secretary determines are designed to secure maximum participation of local, regional, or metropolitan agencies and groups in the provision of such services; (iii) such funds will be used to supplement and, to the extent practical, to increase the level of funds that would otherwise be made available for the purposes for which the Federal funds are provided and not to supplant such non-Federal funds; and (iv) the plan is compatible with the total health program of the State;

[(D) provide for the furnishing of public health services under the State plan in accordance with such plans as have been developed pursuant to subsection (a) ;

[(E) provide that public health services furnished under the plan will be in accordance with standards prescribed by regulations, including standards as to the scope and quality of such services;

[(F) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

[(G) provide that the State health authority or, with respect to mental health authority, will from time to time, but not less often than annually, review and evaluate its State plan approved under this subsection and submit to the Secretary appropriate modifications thereof;

[(H) provide that the State health authority or, with respect to mental health services, the State mental health authority, will make such reports, in such form and containing such information, as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of such reports;

[(I) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds paid to the State under this subsection ;

[(J) contain such additional information and assurances as the Secretary may find necessary to carry out the purposes of this subsection ;

[(K) provide for services for the prevention and treatment of drug abuse and drug dependence, commensurate with the extent of the problem, and include provisions for (i) licensing or accreditation of facilities in which treatment and rehabilitation programs are conducted for persons with drug abuse and other drug dependence problems, and (ii) expansion of State mental health programs in the field of drug abuse and drug dependence and of other prevention and treatment programs in such field; and

[(L) provide for services for the prevention and treatment of alcohol abuse and alcoholism, commensurate with the extent of the problem.

[(3) STATE ALLOTMENTS.—From the sums appropriated to carry out the provisions of this subsection the several States shall be entitled for each fiscal year to allotments determined, in accordance with regulations, on the basis of the population and financial need of the respective States, except that no State's allotments shall be less for any year than the total amounts allotted to such State under formula grants for cancer control, plus other allotments under this section, for the fiscal year ending June 30, 1967.

[(4) (A) PAYMENTS TO STATES.—From each State's allotment under this subsection for a fiscal year, the State shall be paid the Federal share of the expenditures incurred during such year under its State plan approved under this subsection. Such payments shall be made from time to time in advance on the basis of estimates by the Secretary of the sums the State will expend under the State plan, except that such adjustments as may be necessary shall be made on account of previously made underpayments or overpayments under this subsection.

[(B) For the purpose of determining the Federal share for any State, expenditures by nonprofit private agencies, organizations, and groups shall, subject to such limitations and conditions as may be prescribed by regulations, be regarded as expenditures by such State or a political subdivision thereof.

[(5) FEDERAL SHARE.—The "Federal share" for any State for purposes of this subsection shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the United States; except that in no case shall such percentage be less than $33\frac{1}{3}$ per centum or more than $66\frac{2}{3}$ per centum, and except that the Federal share for the Commonwealth of Puerto Rico, Guam, American Samoa, the Trust Territory of the Pacific Islands, and the Virgin Islands shall be $66\frac{2}{3}$ per centum.

[(6) DETERMINATION OF FEDERAL SHARES.—The Federal shares shall be determined by the Secretary between July 1 and September 1 of each year, on the basis of the average per capita incomes of each of the States and of the United States for the most recent year for which satisfactory data are available from the Department of Commerce, and such determination shall be conclusive for the fiscal year beginning on the next July 1. The populations of the several States shall be determined on the basis of the latest figures for the population of the several States available from the Department of Commerce.

[(7) ALLOCATION OF FUNDS WITHIN THE STATES.—At least 15 per centum of a State's allotment under this subsection shall be available only to the State mental health authority for the provision under the State plan of mental health services. Effective with respect to allotments under this subsection for fiscal years ending after June 30, 1968, at least 70 per centum of such amount reserved for mental health services and at least 70 per centum of the remainder of a State's allotment under this subsection shall be available only for the provision under the State plan of services in communities of the State.]

"Comprehensive Public Health Services

"(d) (1) From allotments made pursuant to paragraph (4), the Secretary shall make grants to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services.

"(2) No grant may be made under paragraph (1) to the State health or mental health authority of any State unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary may require, and shall contain or be supported by assurances satisfactory to the Secretary that—

"(A) the comprehensive public health services provided within the State will be provided in accordance with the State plan prepared in accordance with section 1524(c)(2) or the State plan approved under section 314(a), whichever is applicable;

"(B) funds received under grants under paragraph (1) will (i) be used to supplement and, to the extent practical, to increase the level of non-Federal funds that would otherwise be made available for the purposes for which the grant funds are provided, and (ii) not be used to supplant such non-Federal funds;

"(C) the State health authority, and, with respect to mental health activities, the State mental health authority will—

"(i) provide for such fiscal control and fund accounting procedures as may be necessary to assure the proper disbursement of and accounting for funds received under grants under paragraph (1);

"(ii) from time to time, but not less often than annually, report to the Secretary (through a uniform national reporting system and by such categories as the Secretary may prescribe) a description of the comprehensive public health services provided in the State in the fiscal year for which the grant applied for is made and the amount of funds obligated in such fiscal year for the provision of each such category of services; and

"(iii) make such reports (in such form and containing such information as the Secretary may prescribe) as the Secretary may reasonably require, and keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness of, and to verify, such reports;

"(D) the State mental health authority will—

"(i) establish and carry out a plan which—

"(I) is designed to eliminate inappropriate placement of persons with mental health problems in institutions, to insure the availability of appropriate noninstitutional services for such persons, and to improve the quality of care for those with mental health problems for whom institutional care is appropriate; and

"(II) shall include fair and equitable arrangements, as determined by the Secretary, to protect the interests of employees affected by actions taken pursuant to such plan, including arrangements designed (to the extent

feasible as determined by the Secretary) to preserve employee rights and benefits and to provide appropriate training and retraining of such employees who are employed by the State or any of its political subdivisions;

"(ii) prescribe and provide for the enforcement of minimum standards for the maintenance and operation of mental health programs and facilities (including community mental health centers) with the State; and

"(iii) provide for assistance to courts and other public agencies and to appropriate private agencies to facilitate (I) screening by community mental health centers (or, if there are no such centers, other appropriate entities) of residents of the State who are being considered for inpatient care in a mental facility to determine if such care is necessary, and (II) provision of followup care by community mental health centers (or, if there are no such centers, by other appropriate entities) for residents of the State who have been discharged from mental health facilities.

"(3) The Secretary shall review annually the activities undertaken by each State with an approved application to determine if the State complied with the assurances provided with the application. The Secretary may not approve an application submitted under paragraph (2) if the Secretary determines—

"(A) that the State for which the application was submitted did not comply with assurances provided with a prior application under paragraph (2), and

"(B) that he cannot be assured that the State will comply with the assurances provided with the application under consideration.

"(4) In each fiscal year the Secretary shall, in accordance with regulations, allot the sums appropriated for such year under paragraph (7) among the States on the basis of the population and the financial need of the respective States. The populations of the States shall be determined on the basis of the latest figures for the population of the States available from the Department of Commerce.

"(5) The Secretary shall determine the amount of any grant under paragraph (1); but the amount of grants made in any fiscal year to the public and mental health authorities of any State may not exceed the amount of the State's allotment available for obligation in such fiscal year. Payments under such grants may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

"(6) In any fiscal year—

"(A) not less than 15 per centum of a State's allotment under paragraph (4) shall be made available only for grants under paragraph (1) to the State's mental health authority for the provision of mental health services; and

"(B) not less than—

"(i) 70 per centum of the amount of a State's allotment which is made available for grants to the mental health authority, and

"(ii) 70 per centum of the remainder of the State's allotment,

shall be available only for the provision services in communities of the State.

"(7) (A) For payments under grants under paragraph (1) there are authorized to be appropriated \$100,000,000 for fiscal year 1976, and \$110,000,000 for fiscal year 1977.

"(B) For payments under grants under paragraph (1) for establishing and maintaining programs, described in applications under paragraph (2), for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension there are authorized to be appropriated \$15,000,000 for fiscal year 1976, and \$15,000,000 for fiscal year 1977."

【Project Grants for Health Services Development

【(e) There are authorized to be appropriated \$90,000,000 for the fiscal year ending June 30, 1968, \$95,000,000 for the fiscal year ending June 30, 1969, \$80,000,000 for the fiscal year ending June 30, 1970, \$109,500,000 for the fiscal year ending June 30, 1971, \$135,000,000 for the fiscal year ending June 30, 1972, \$157,000,000 for the fiscal year ending June 30, 1973, and \$230,700,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, for grants to any public or nonprofit private agency, institution, or organization to cover part of the cost (including equity requirements and amortization of loans on facilities acquired from the Office of Economic Opportunity or construction in connection with any program or project transferred from the Office of Economic Opportunity) of (1) providing services (including related training) to meet health needs of limited geographic scope or of specialized regional or national significance, or (2) developing and supporting for an initial period new programs of health services (including related training). Any grant made under this subsection may be made only if the application for such grant has been referred for review and comment to the appropriate areawide health planning agency or agencies (or, if there is no such agency in the area, then to such other public or nonprofit private agency or organization (if any) which performs similar functions) and only if the services assisted under such grant will be provided in accordance with such plans as have been developed pursuant to subsection (a). No grant may be made under this subsection for the fiscal year ending June 30, 1975, to cover the cost of services described in clause (1) or (2) of the first sentence if a grant or contract to cover the cost of such services may be made or entered into from funds authorized to be appropriated for such fiscal year under an authorization of appropriations in any provision of this Act (other than this subsection) amended by title VII of the Health Revenue Sharing Services Act of 1975.

【No funds appropriated pursuant to the authorization of this subsection shall be available for lead based paint poisoning control of the type authorized under the Lead Based Paint Poisoning Prevention Act (84 Stat. 2078).】

* * * * *

GRANTS FOR VACCINATION PROGRAMS AND OTHER COMMUNICABLE DISEASE
CONTROL PROGRAMS

SEC. 317. (a) * * *

* * * * *

(d) (1) There is authorized to be appropriated \$11,000,000 for the fiscal year ending June 30, 1973, \$11,000,000 for the fiscal year ending June 30, 1974, and \$11,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable and other disease control programs for tuberculosis.

(2) There is authorized to be appropriated \$6,000,000 for the fiscal year ending June 30, 1973, \$6,000,000 for the fiscal year ending June 30, 1974, and \$6,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable and other disease control programs for measles.

(3) There is authorized to be appropriated \$23,000,000 for the fiscal year ending June 30, 1973, \$23,000,000 for the fiscal year ending June 30, 1974, and \$23,000,000 for the fiscal year ending June 30, 1975, for grants under this section for communicable and other disease control programs other than communicable and other disease control programs for which appropriations are authorized by paragraph (1) or (2). *There is authorized to be appropriated for fiscal year 1976 \$20,000,000 for grants under this section for communicable and other disease control programs for diseases borne by rodents.*

(4) Not to exceed 50 per centum of the amount appropriated for any fiscal year under any of the preceding paragraphs of this subsection may be used by the Secretary for grants for such fiscal year under (A) programs for which appropriations are authorized under any one or more of the other paragraphs of this subsection if the Secretary determines that such use will better carry out the purposes of this section, and (B) section 318.

* * * * *

(h) For the purposes of this section:

(1) The term "communicable and other disease control program" means a program which is designed and conducted so as to contribute to national protection against diabetes mellitus [and], Rh disease, and *diseases borne by rodents*, tuberculosis, rubella, measles, poliomyelitis, diphtheria, tetanus, whooping cough, or other communicable diseases (other than venereal disease) which are transmitted from State to State, are amenable to reduction, and are determined by the Secretary to be of national significance. Such term includes vaccination programs, laboratory services, and studies to determine the communicable disease control needs of States and political subdivisions of States and the means of best meeting such needs.

* * * * *

[HEALTH SERVICES FOR DOMESTIC AGRICULTURAL MIGRANTS

[SEC. 319. There are hereby authorized to be appropriated not to exceed \$7,000,000 for the fiscal year ending June 30, 1966, \$8,000,000 for the fiscal year ending June 30, 1967, \$9,000,000 each for the fiscal

year ending June 30, 1968, and the next fiscal year, \$15,000,000 for the fiscal year ending June 30, 1970, \$20,000,000 for the fiscal year ending June 30, 1971, \$25,000,000 for the fiscal year ending June 30, 1972, \$30,000,000 for the fiscal year ending June 30, 1973, and \$26,750,000 each for the fiscal years ending June 30, 1974, and June 30, 1975. To enable the Secretary (1) to make grants to public and other nonprofit agencies, institutions, and organizations for paying part of the cost of (i) establishing and operating family health service clinics for domestic agricultural migratory workers and their families, including training persons (including allied health professions personnel) to provide services in the establishing and operating of such clinics, and (ii) special projects to improve and provide a continuity in health services for and to improve the health conditions of domestic agricultural migratory workers and their families, including necessary hospital care, and including training persons (including allied health professions personnel) to provide health services for or otherwise improve the health conditions of such migratory workers and their families, and (2) to encourage and cooperate in programs for the purpose of improving health services for or otherwise improving the health conditions of domestic agricultural migratory workers and their families. The Secretary may also use funds appropriated under his section to provide health services to persons (and their families) who perform seasonal agricultural services similar to the services performed by domestic agricultural migratory workers if the Secretary finds that the provision of health services under this sentence will contribute to the improvement of the health conditions of such migratory workers and their families. For the purposes of assessing and meeting domestic migratory agricultural workers' health needs, developing necessary resources, and involving local citizens in the development and implementation of health care programs authorized by this section, the Secretary must be satisfied, upon the basis of evidence supplied by each applicant, that persons broadly representative of all elements of the population to be served and others in the community knowledgeable about such needs have been given an opportunity to participate in the development of such programs, and will be given an opportunity to participate in the implementation of such programs.】

MIGRANT HEALTH

SEC. 319. (a) For purposes of this section:

(1) The term "migrant health center" means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

(A) primary health services,

(B) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

(C) referral to providers of supplemental health services and payment, as appropriate and feasible, for their provision of such services,

(D) environmental health services, including, as may be appropriate for particular centers, the detection and alleviation of

unhealthful conditions associated with water supply, sewage treatment, solid waste disposal, rodent and parasite infestation, field sanitation, housing, and other environmental factors related to health,

(E) as may be appropriate for particular centers, infectious and parasitic disease screening and control,

(F) as may be appropriate for particular centers, accident prevention programs, including prevention of excessive pesticide exposure, and

(G) information on the availability and proper use of health services,

for migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, within the area it serves (referred to in this section as a "catchment area").

(2) The term "migratory agricultural worker" means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes for the purposes of such employment a temporary abode.

(3) The term "seasonal agricultural workers" means an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

(4) The term "agriculture" means farming in all its branches, including—

(A) cultivation and tillage of the soil,

(B) the production, cultivation, growing, and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on, the land, and

(C) any practice (including preparation and processing for market and delivery to storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity described in subparagraph (B).

(5) The term "high impact area" means a health service area or other area which has not less than six thousand migratory agricultural workers and seasonal agricultural workers residing within its boundaries for more than two months in any calendar year. In computing the number of workers residing in an area, there shall be included as workers the members of the families of such workers.

(6) The term "primary health services" means—

(A) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;

(B) diagnostic laboratory and radiologic services;

(C) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);

(D) emergency medical services;

(E) transportation services as required for adequate patient care; and

(F) preventive dental services.

(7) The term "supplemental health services" means services which are not included as primary health services and which are—

- (A) hospital services;
- (B) home health services;
- (C) extended care facility services;
- (D) rehabilitative services (including physical therapy) and long-term physical medicine;
- (E) mental health services;
- (F) dental services;
- (G) vision services;
- (H) allied health services;
- (I) pharmaceutical services;
- (J) therapeutic radiologic services;
- (K) public health services (including nutrition education and social services);
- (L) health education services; and
- (M) services which promote and facilitate optimal use of primary health services and the services referred to in the preceeding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a migrant health center are of limited English-speaking ability, the services of outreach workers fluent in the language spoken by a predominant number of such individuals.

(b) (1) The Secretary shall assign to high impact areas and any other areas (where appropriate) priorities for the provision of assistance under this section to projects and programs in such areas. The highest priorities for such assistance shall be assigned to areas in which reside the greatest number of migratory agricultural workers and the members of their families for the longest period of time.

(2) No application for a grant under subsection (c) or (d) for a project in an area which has no migratory agricultural workers may be approved unless grants have been provided for all approved applications under such subsections for projects in areas with migratory agricultural workers.

(c) (1) (A) The Secretary may, in accordance with the priorities assigned under subsection (b) (1), make grants to public and nonprofit private entities for projects to plan and develop migrant health centers which will serve migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in high impact areas. A project for which a grant may be made under this subparagraph may include the cost of the acquisition and modernization of existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans) and the costs of providing training related to the management of migrant health center programs, and shall include—

(i) an assessment of the need that the workers (and members of the families of such workers) proposed to be served by the migrant health center for which the project is undertaken have for the primary health services, supplemental health services, and environmental health services;

(ii) the design of a migrant health center program for such workers and the members of their families, based on such assessment;

(iii) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

(iv) initiation and encouragement of continuing community involvement in the development and operation of the project.

(B) The Secretary may make grants to or enter into contracts with public and nonprofit private entities for projects to plan and develop programs in areas in which no migrant health center exists and which are not high impact areas—

(i) for the provision of emergency care to migratory agricultural workers, seasonal agricultural workers, and the members of families of such migratory and seasonal workers;

(ii) for the provision of primary care (as defined in regulations of the Secretary) for such workers and the members of their families;

(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

(iv) which otherwise improve the health of such workers and their families.

Any such program may include the acquisition and modernization of existing buildings and providing training related to the management of programs assisted under this subparagraph.

(2) Not more than two grants may be made under paragraph (1) (A) for the same project, and if a grant or contract is made or entered into under paragraph (1) (B) for a project, no other grant or contract under that paragraph may be made or entered into for the project.

(3) The amount of any grant made under paragraph (1) for any project shall be determined by the Secretary.

(d) (1) (A) The Secretary may, in accordance with priorities assigned under subsection (b) (1), make grants for the costs of operation of public and nonprofit private migrant health centers in high impact areas.

(B) The Secretary may, in accordance with priorities assigned under subsection (b) (1), make grants for the costs of the operation of public and nonprofit entities which intend to become migrant health centers, which provide health services in high impact areas to migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, but with respect to which he is unable to make each of the determinations required by subsection (f) (2). Not more than two grants may be made under this subparagraph for any entity.

(C) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects for the operation of programs in areas in which no migrant health center exists and which are not high impact areas—

(i) for the provision of emergency care to migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers;

(ii) for the provision of primary care (as defined in regulations of the Secretary) for such workers and the members of their families;

(iii) for the development of arrangements with existing facilities to provide primary health services (not included as primary care as defined under regulations under clause (ii)) to such workers and the members of their families; or

(iv) which otherwise improve the health of such workers and the members of their families.

Any such program may include the acquisition and modernization of existing buildings and providing training related to the management of programs assisted under this subparagraph.

(2) The costs for which a grant may be made under paragraph (1)(A) or (1)(B) may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying the interest on, loans); and the costs for which a grant or contract may be made under paragraph (1) may include the costs of providing training related to the provision of primary health services, supplemental health services, and environmental health services, and to the management of migrant health center programs.

(3) The amount of any grant made under paragraph (1) shall be determined by the Secretary.

(e) The Secretary may enter into contracts with public and private entities to—

(1) assist the States in the implementation and enforcement of acceptable environmental health standards, including enforcement of standards for sanitation in migrant labor camps and applicable Federal and State pesticide control standards; and

(2) conduct projects and studies to assist the several States and entities which have received grants or contracts under this section in the assessment of problems related to camp and field sanitation, pesticide hazards, and other environmental health hazards to which migratory agricultural workers, seasonal agricultural workers, and members of their families are exposed.

(f) (1) No grant may be made under subsection (c) or (d) and no contract may be entered into under subsection (c) (1)(B), (d) (1)(C), or (e) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant or contract which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

(A) a description of the site of the building,

(B) plans and specifications for its modernization, and

(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

(2) *The Secretary may not approve an application for a grant under subsection (d) (1) (A) unless the Secretary determines that the entity for which the application is submitted is a migrant health center (within the meaning of subsection (a) (1)) and that—*

(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

(B) the center will have organizational arrangements, established in accordance with regulations of the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(F) the center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

(G) the center has established a governing board which (i) is composed of individuals a majority of whom are being served by the center and who, as a group, represent the individuals being served by the center, and (ii) establishes general policies for the center (including the selection of services to be provided by the center and a schedule of hours during which services will be provided), approves the center's annual budget, and approves the selection of a director for the center;

(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, and (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require;

(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the migratory agricultural workers, seasonal agricultural workers, and the members of the families of such migratory and seasonal workers, in the area promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

(3) In considering applications for grants and contracts under subsection (c) or (d) (1) (C), the Secretary shall give priority to applications submitted by community-based organizations which are representatives of the populations to be served through the projects, programs, or centers to be assisted by such grants or contracts.

(4) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(g) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant or contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any migrant health center or to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a migrant health center, and in meeting the requirements of subsection (f) (2).

(h) (1) There are authorized to be appropriated for payments pursuant to grants and contracts under subsection (c) (1) \$4,000,000 for

fiscal year 1976, and \$4,000,000 for fiscal year 1977. Of the funds appropriated under this paragraph for fiscal year 1976, not more than 30 per centum of such funds may be made available for grants and contracts under subsection (c) (1) (B), and of the funds appropriated under this paragraph for the next fiscal year, not more than 25 per centum of such funds may be made available for grants and contracts under such subsection.

(2) There are authorized to be appropriated for payments pursuant to grants and contracts under subsection (d) (1) (other than for payments under such grants and contracts for the provision of inpatient and outpatient hospital services) and for payments pursuant to contracts under subsection (e) \$30,000,000 for fiscal year 1976, and \$35,000,000 for fiscal year 1977. Of the funds appropriated under the first sentence for fiscal year 1976, there shall be made available for grants and contracts under subsection (d) (1) (C) an amount not exceeding the greater of 30 per centum of such funds or 90 per centum of the amount of grants made under this section for the preceding fiscal year for programs described in subsection (d) (1) (C). Of the funds appropriated under the first sentence for fiscal year 1977, there shall be made available for grants and contracts under subsection (d) (1) (C) an amount not exceeding the greater of 25 per centum of such funds or 90 per centum of the amount of grants made under this section for the preceding fiscal year for programs described in subsection (d) (1) (C) which received grants under this section for the fiscal year ending June 30, 1975. Of the funds appropriated under this paragraph for any fiscal year, not more than 10 per centum of such funds may be made available for contracts under subsection (e).

(3) There are authorized to be appropriated for payments under grants and contracts under subsection (d) (1) for the provision of inpatient and outpatient hospital services \$5,000,000 for fiscal year 1976, and \$5,000,000 for fiscal year 1977.

PART C—HOSPITALS, MEDICAL EXAMINATIONS, AND MEDICAL CARE

* * * * *

COMMUNITY HEALTH CENTERS

SEC. 330. (a) For purposes of this section, the term "community health center" means an entity which either through its staff and supporting resources or through contracts or cooperative arrangements with other public or private entities provides—

(1) primarily health services,

(2) as may be appropriate for particular centers, supplemental health services necessary for the adequate support of primary health services,

(3) referral to providers of supplemental health services and payments, as appropriate and feasible, for their provision of such services,

(4) as may be appropriate for particular centers, environmental health services, and

(5) *information on the availability and proper use of health services, for all residents of the area it serves (referred to in this section as a "catchment area").*

(b) *For purposes of this section:*

(1) *The term "primary health services" means—*

(A) *services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;*

(B) *diagnostic laboratory and radiologic services;*

(C) *preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);*

(D) *emergency medical services;*

(E) *transportation services as required for adequate patient care; and*

(F) *preventive dental services.*

(2) *The term "supplemental health services" means services which are not included as primary health services and which are—*

(A) *hospital services;*

(B) *home health services;*

(C) *extended care facility services;*

(D) *rehabilitative services (including physical therapy) and long-term physical medicine;*

(E) *mental health services;*

(F) *dental services;*

(G) *vision services;*

(H) *allied health services;*

(I) *pharmaceutical services;*

(J) *therapeutic radiologic services;*

(K) *public health services (including nutrition education and social services);*

(L) *health education services; and*

(M) *services which promote and facilitate optimal use of primary health services and the services referred to in the preceding subparagraphs of this paragraph, including, if a substantial number of the individuals in the population served by a community health center are of limited English-speaking ability, the services of outreach workers fluent in the language spoken by a predominant number of such individuals.*

(3) *The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services.*

(c)(1) *The Secretary may make grants to public and nonprofit private entities for projects to plan and develop community health centers which will serve medically underserved populations. A project for which a grant may be made under this subsection may include the cost of the acquisition and modernization of existing buildings (in-*

cluding the costs of amortizing the principal of, and paying the interest on, loans) and shall include—

(A) an assessment of the need that the population proposed to be served by the community health center for which the project is undertaken has for primary health services, supplemental health services, and environmental health services;

(B) the design of a community health center program for such population based on such assessment;

(C) efforts to secure, within the proposed catchment area of such center, financial and professional assistance and support for the project; and

(D) initiation and encouragement of continuing community involvement in the development and operation of the project.

(2) Not more than two grants may be made under this subsection for the same project.

(3) The amount of any grant made under this subsection for any project shall be determined by the Secretary.

(d) (1) (A) The Secretary may make grants for the costs of operation of public and nonprofit private community health centers which serve medically underserved populations.

(B) The Secretary may make grants for the costs of the operation of public and nonprofit private entities which provide health services to medically underserved populations but with respect to which he is unable to make each of the determinations required by subsection (e) (2).

(2) The costs for which a grant may be made under paragraph (1) may include the costs of acquiring and modernizing existing buildings (including the costs of amortizing the principal of, and paying interest on, loans) and the costs of providing training related to the provision of primary health services, supplemental health services and environmental health services, and to the management of community health center programs.

(3) Not more than two grants may be made under paragraph (1) (B) for the same entity.

(4) The amount of any grant made under paragraph (1) shall be determined by the Secretary.

(e) (1) No grant may be made under subsection (e) or (d) unless an application therefor is submitted to, and approved by, the Secretary. Such an application shall be submitted in such form and manner and shall contain such information as the Secretary shall prescribe. An application for a grant which will cover the costs of modernizing a building shall include, in addition to other information required by the Secretary—

(A) a description of the site of the building.

(B) plans and specifications for its modernization, and

(C) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on the modernization of the building will be paid wages at rates not less than those prevailing on similar work in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act).

The Secretary of Labor shall have with respect to the labor standards referred to in subparagraph (C) the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176, 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c).

(2) *Except as provided in subsection (d)(1)(B), the Secretary may not approve an application for a grant under subsection (d) unless the Secretary determines that the entity for which the application is submitted is a community health center (within the meaning of subsection (a)) and that—*

(A) the primary health services of the center will be available and accessible in the center's catchment area promptly, as appropriate, and in a manner which assures continuity;

(B) the center will have organizational arrangements, established in accordance with regulations prescribed by the Secretary, for (i) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, and (ii) maintaining the confidentiality of patient records;

(C) the center will demonstrate its financial responsibility by the use of such accounting procedures and other requirements as may be prescribed by the Secretary;

(D) the center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved under title XIX of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

(E) the center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(F) the center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments, which discounts are adjusted on the basis of the patient's ability to pay, (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such schedules, and (II) to collect reimbursement for health services to persons described in subparagraph (E) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph;

(G) the center has established a governing board which (i) is composed of individuals a majority of whom are being served by the center and who, as a group, represent the individuals being

served by the center, and (ii) meets at least once a month, establishes general policies for the center (including the selection of services to be provided by the center and a schedule of hours during which services will be provided), approves the center's annual budget, and approves the selection of a director for the center;

(H) the center has developed, in accordance with regulations of the Secretary, (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for compiling and reporting to the Secretary such statistics and other information as the Secretary may require relating to (I) the costs of its operations, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, and (IV) such other matters relating to operations of the applicant as the Secretary may, by regulation, require;

(I) the center will review periodically its catchment area to (i) insure that the size of such area is such that the services to be provided through the center (including any satellite) are available and accessible to the residents of the areas promptly and as appropriate, (ii) insure that the boundaries of such area conform, to the extent practicable, to relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (iii) insure that the boundaries of such area eliminate, to the extent possible, barriers to access to the services of the center, including barriers resulting from the area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation; and

(J) in the case of a center which serves a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both the language and in English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences.

(f) The Secretary may provide (either through the Department of Health, Education, and Welfare or by grant of contract) all necessary technical and other nonfinancial assistance (including fiscal and program management assistance and training in such management) to any public or private nonprofit entity to assist it in developing plans for, and in operating as, a community health center, and in meeting requirements of subsection (e) (2).

(g) (1) There are authorized to be appropriated for payments pursuant to grants under subsection (e) \$5,000,000 for fiscal year 1976, and \$5,000,000 for fiscal year 1977.

(2) There are authorized to be appropriated for payments pursuant to grants under subsection (d) \$215,000,000 for fiscal year 1976, and \$235,000,000 for fiscal year 1977.

PART K—QUALITY ASSURANCE

QUALITY ASSURANCE

SEC. [399c] 399A.¹ (a)(1) The Secretary, through the Assistant Secretary for Health, shall conduct research and evaluation programs respecting the effectiveness, administration, and enforcement of quality assurance programs. Such research and evaluation programs shall be carried out in cooperation with the entity within the Department which administers the programs of assistance under section 304.

(2) For the purpose of carrying out paragraph (1), there are authorized to be appropriated \$4,000,000 for the fiscal year ending June 30, 1974, \$8,000,000 for the fiscal year ending June 30, 1975, \$9,000,000 for the fiscal year ending June 30, 1976, \$9,000,000 for the fiscal year ending June 30, 1977, and \$10,000,000 for the fiscal year ending June 30, 1978.

(b) The Secretary shall make an annual report to the Congress and the President on (1) the quality of health care in the United States, (2) the operation of quality assurance programs, and (3) advances made through research and evaluation of the effectiveness, administration, and enforcement of quality assurance programs. The first annual report under this subsection shall be made with respect to calendar year 1974 and shall be submitted not later than March 1, 1975. The Office of Management and Budget may review the Secretary's report under this subsection before its submission to the Congress, but the Office may not revise the report or delay its submission to the Congress, and it may submit to the Secretary and the Congress its comments (and those of other departments and agencies of the Government) with respect to such report.

¹ This amendment shall take effect on the date of the enactment of this Act.

TITLE IV—NATIONAL RESEARCH INSTITUTES

PART A—NATIONAL CANCER INSTITUTE

PART I—GENERAL PROVISIONS

PEER REVIEW OF GRANT APPLICATIONS AND CONTRACT PROJECTS

SEC. 475.¹ (a) The Secretary, after consultation with the Director of the National Institutes of Health, and, where appropriate, the Directors of the National Institute of Mental Health, the National Institute on Alcohol Abuse and Alcoholism, and the National Institute on Drug Abuse, shall by regulation require appropriate scientific peer review of—

(1) applications made after the effective date of such regulations for grants under this Act for biomedical and behavioral research; and

(2) biomedical and behavioral research and development contract projects to be administered after such effective date through an institute established under this title, the National Institute on Alcohol Abuse and Alcoholism, or the National Institute on Drug Abuse.

(b) Regulations promulgated under subsection (a) shall, to the extent practical, require that the review of grant applications required by the regulations be conducted—

(1) in a manner consistent with the system for scientific peer review applicable on the date of the enactment of this section to applications for grants under this Act for biomedical and behavioral research, and

(2) by peer review groups performing such review on or before such date.

(c) The members of any peer review group established under such regulations shall be individuals who by virtue of their training or experience are eminently qualified to perform the review functions of the group and not more than one-fourth of the members of any peer review group established under such regulations shall be officers or employees of the United States.

* * * * *

¹ This amendment shall take effect on the date of enactment of this Act.

TITLE X—POPULATION RESEARCH AND VOLUNTARY FAMILY PLANNING PROGRAMS

PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES

SEC. 1001. (a) The Secretary is authorized to make grants to and enter into contracts with public or nonprofit private entities to assist in the establishment and operation of voluntary family planning projects *which shall offer a broad range of acceptable and effective family planning methods (including natural family planning methods)*.

(b) In making grants and contracts under this section the Secretary shall take into account the number of patients to be served, the extent to which family planning services are needed locally, the relative need of the applicant, and its capacity to make rapid and effective use of such assistance. *Local and regional entities shall be assured the right to apply for, and be direct recipients of, grants and contracts under this section, and the Secretary shall by regulation fully provide for and protect such right.*

(c) For the purpose of making grants and contracts under this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971; \$60,000,000 for the fiscal year ending June 30, 1972; and \$111,500,000 for the fiscal year ending June 30, 1973, **[and]** \$111,500,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; *\$110,000,000 for fiscal year 1976; and \$120,000,000 for fiscal year 1977.*

* * * * *

TRAINING GRANTS AND CONTRACTS

SEC. 1003. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to provide the training for personnel to carry out family planning service programs described in section 1001 or 1002.

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$2,000,000 for the fiscal year ending June 30, 1971; \$3,000,000 for the fiscal year ending June 30, 1972; \$4,000,000 for the fiscal year ending June 30, 1973; **[and]** \$3,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; *\$4,000,000 for fiscal year 1976; and \$5,000,000 for fiscal year 1977.*

[RESEARCH GRANTS AND CONTRACTS

[SEC. 1004. (a) In order to promote research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population, the Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals for projects for research and research training in such fields.

[(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971; \$50,000,000 for the fiscal year ending June 30, 1972; \$65,000,000 for the fiscal year ending June 30, 1973; and \$2,615,000 each for the fiscal years ending June 30, 1974, and June 30, 1975.]

RESEARCH

SEC. 1004. (a) *The Secretary may—*

(1) *conduct, and*

(2) *make grants to public or nonprofit private entities and enter into contracts with public or private entities and individuals for projects for, research in the biomedical, contraceptive development, behavioral, and program implementation fields related to family planning and population.*

(b) (1) *To carry out subsection (a) there are authorized to be appropriated \$55,000,000 for fiscal year 1976, and \$60,000,000 for fiscal year 1977.*

(2) *No funds appropriated under any provision of this Act (other than this subsection) may be used to conduct or support the research described in subsection (a).*

INFORMATIONAL AND EDUCATIONAL MATERIALS

SEC. 1005. (a) The Secretary is authorized to make grants to public or nonprofit private entities and to enter into contracts with public or private entities and individuals to assist in developing and making available family planning and population growth information (including educational materials) to all persons desiring such information (or materials).

(b) For the purpose of making payments pursuant to grants and contracts under this section, there are authorized to be appropriated \$750,000 for the fiscal year ending June 30, 1971; \$1,000,000 for the fiscal year ending June 30, 1972; \$1,250,00 for the fiscal year ending June 3, 1973; [and] \$909,000 each for the fiscal years ending June 30, 1974, and June 30, 1975; \$2,000,000 for fiscal year 1976; and \$2,500,000 for fiscal year 1977.

REGULATIONS AND PAYMENTS

SEC. 1006. (a) Grants and contracts made under this title shall be made in accordance with such regulations as the Secretary may promulgate. *The amount of any grant under any section of this title*

shall be determined by the Secretary; except that no grant under any such section for any program or project for a fiscal year beginning after June 30, 1975, may be made for less than 90 per centum of its cost (as determined under regulations of the Secretary) unless the grant is to be made for a program or project for which a grant was made (under the same section) for the fiscal year ending June 30, 1975, for less than 90 per centum of its costs (as to determined), in which case a grant under such section for that program or project for a fiscal year beginning after that date may be made for a percentage which shall not be less than the percentage of its costs for which the fiscal year 1975 grant was made.

(b) Grants under this title shall be payable in such installments and subject to such conditions as the Secretary may determine to be appropriate to assure that such grants will be effectively utilized for the purposes for which made.

(c) A grant may be made or contract entered into under section 1001 or 1002 for a family planning service project or program only upon assurances satisfactory to the Secretary that—

(1) priority will be given in such project or program to the furnishing of such services to persons from low-income families; and

(2) no charge will be made in such project or program for services provided to any person from a low-income family except to the extent that payment will be made by a third party (including a government agency) which is authorized or is under legal obligation to pay such charge.

For purposes of this subsection, the term "low-income family" shall be defined by the Secretary in accordance with such criteria as he may prescribe so as to insure that economic status shall not be a deterrent to participation in the programs assisted under this title.

* * * * *

PLANS AND REPORTS

SEC. 1009. (a) Not later than four months after the close of each fiscal year, the Secretary shall make a report to the Congress setting forth a plan to be carried out over the next five fiscal years for—

(1) extension of family planning services to all persons desiring such services,

(2) family planning and population research programs,

(3) training of necessary manpower for the programs authorized by this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning, and

(4) carrying out the other purposes set forth in this title and the Family Planning Services and Population Research Act of 1970.

(b) Such a plan shall, at a minimum, indicate on a phased basis—

(1) the number of individuals to be served by family planning programs under this title and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be

developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet the purposes of this title and other Federal laws for which the Secretary has responsibility and which pertain to family planning programs; and

(3) the steps to be taken to maintain a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.

(c) Each report submitted under subsection (a) shall—

(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan contained in the previous such report;

(2) indicate steps being taken to achieve the objectives during the fiscal years covered by the plan contained in such report and any revisions to plans in previous reports necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan contained in such report.

TITLE XI—GENETIC BLOOD DISORDERS AND SUDDEN INFANT DEATH SYNDROME

* * * * *

PART D—HEMOPHILIA PROGRAMS

TREATMENT CENTERS

SEC. 1131. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects for the establishment of comprehensive hemophilia diagnostic and treatment centers. A center established under this subsection shall provide—

(1) access to the services of the center for all individuals suffering from hemophilia who reside within the geographic area served by the center;

(2) programs for the training of professional and paraprofessional personnel in hemophilia research, diagnosis, and treatment;

(3) a program for the diagnosis and treatment of individuals suffering from hemophilia who are being treated on an outpatient basis;

(4) a program for association with providers of health care who are treating individuals suffering from hemophilia in areas not conveniently served directly by such center but who are more conveniently (as determined by the Secretary) served by it than by the next geographically closest center;

(5) programs of social and vocational counseling for individuals suffering from the hemophilia; and

(6) individualized written comprehensive care programs for each individual treated by or in association with such center.

(b) No grant or contract may be made under subsection (a) unless an application therefor has been submitted to and approved by the Secretary. Such application shall be in such form, submitted in such manner, and contain such information, as the Secretary shall by regulation prescribe.

(c) An application for a grant or contract under subsection (a) shall contain assurances satisfactory to the Secretary that the applicant will serve the maximum number of individuals that its available and potential resources will enable it to effectively serve.

(d) In considering applications for grants and contracts under subsection (a) for projects to establish hemophilia diagnostic and treatment centers, the Secretary shall—

(1) take into account the number of persons to be served by the programs to be supported by such centers and the extent to which rapid and effective use will be made by such centers of funds under such grants and contracts, and

(2) give priority to projects for centers which will operate in areas which the Secretary determines have the greatest number of persons in need of the services provided by such centers.

(e) Contracts may be entered into under subsection (a) without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(f) There are authorized to be appropriated to make payments under grants and contracts under subsection (a) \$3,000,000 for fiscal year 1976, and \$4,000,000 for fiscal year 1977.

BLOOD SEPARATION CENTERS

SEC. 1132. (a) The Secretary may make grants to and enter into contracts with public and nonprofit private entities for projects to develop and expand, within existing facilities, blood-separation centers to separate and make available for distribution blood components to providers of blood services and manufacturers of blood fractions. For purposes of this section—

(1) the term "blood components" means those constituents of whole blood which are used for therapy and which are obtained by physical separation processes which result in licensed products such as red blood cells, platelets, white blood cells, AHF-rich plasma, fresh-frozen plasma, cryoprecipitate, and single unit plasma for infusion; and

(2) the term "blood fractions" means those constituents of plasma which are used for therapy and which are obtained by licensed fractionation processes presently used in manufacturing which result in licensed products such as normal serum albumin, plasma, protein fraction, prothrombin complex, fibrinogen, AHF concentrate, immune serum globulin, and hyperimmune globulins.

(b) In the event the Secretary finds that there is an insufficient supply of blood fractions available to meet the needs for treatment of persons suffering from hemophilia, and that public and other nonprofit private centers already engaged in the production of blood fractions could alleviate such insufficiency with assistance under this subsection, he may make grants not to exceed \$500,000 to such centers for the purposes of alleviating the insufficiency.

(c) No grant or contract may be made under subsection (a) or (b) unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be in such form, submitted in such manner, and contain such information as the Secretary shall by regulation prescribe.

(d) Contracts may be entered into under subsection (a) without regard to section 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(e) For the purpose of making payments under grants and contracts under subsections (a) and (b), there are authorized to be appropriated \$4,000,000 for fiscal year 1976, and \$5,000,000 for fiscal year 1977.

FAMILY PLANNING SERVICES AND POPULATION RESEARCH ACT OF 1970

* * * * *

PLANS AND REPORTS

SEC. 5. (a) Not later than six months after the date of enactment of this Act the Secretary shall make a report to the Congress setting forth a plan, to be carried out over a period of five years, for extension of family planning services to all persons desiring such services, for family planning and population research programs, for training of necessary manpower for the programs authorized by title X of the Public Health Service Act and other Federal laws for which the Secretary has responsibility, and for carrying out the other purposes set forth in this Act and in such title X.

(b) Such a plan shall, at a minimum, indicate on a phased basis—

(1) the number of individuals to be served by family planning programs under title X of the Public Health Service Act and other Federal laws for which the Secretary has responsibility, the types of family planning and population growth information and educational materials to be developed under such laws and how they will be made available, the research goals to be reached under such laws, and the manpower to be trained under such laws;

(2) an estimate of the costs and personnel requirements needed to meet these objectives; and

(3) the steps to be taken to establish a systematic reporting system capable of yielding comprehensive data on which service figures and program evaluations for the Department of Health, Education, and Welfare shall be based.

(c) On or before January 1, 1972, and on or before each January 1 thereafter for a period of five years, the Secretary shall submit to the Congress a report which shall—

(1) compare results achieved during the preceding fiscal year with the objectives established for such year under the plan;

(2) indicate steps being taken to achieve the objective during the remaining fiscal years of the plan and any revisions necessary to meet these objectives; and

(3) make recommendations with respect to any additional legislative or administrative action necessary or desirable in carrying out the plan.]

* * * * *

COMMUNITY MENTAL HEALTH CENTERS ACT ¹

【TITLE II—COMMUNITY MENTAL HEALTH CENTERS

【SHORT TITLE

【SEC. 200. This title may be cited as the “Community Mental Health Centers Act”.

【PART A—GRANTS FOR CONSTRUCTION

【AUTHORIZATION OF APPROPRIATIONS

【SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, \$35,000,000 for the fiscal year ending June 30, 1965, \$50,000,000 for the fiscal year ending June 30, 1966, \$65,000,000 for the fiscal year ending June 30, 1967, \$50,000,000 for the fiscal year ending June 30, 1968, \$60,000,000 for the fiscal year ending June 30, 1969, \$70,000,000 for the fiscal year ending June 30, 1970, \$80,000,000 for the fiscal year ending June 30, 1971, \$90,000,000 for the fiscal year ending June 30, 1972, \$100,000,000 for the fiscal year ending June 30, 1973, and \$20,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975.

【ALLOTMENTS TO STATES

【SEC. 202. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 201 to the several States on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, for any fiscal year may be less than \$100,000. Sums so allotted to a State other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted for such State for such next fiscal year. Sums so allotted to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands for a fiscal year and remaining unobligated at the end of such year shall remain available to it for such purpose for the next two fiscal years (and for such years

¹ The following text shows further changes in existing law which shall take effect on July 1, 1975 (unless otherwise indicated), after the proposed changes in the preceding text have already become effective. The existing law shown in roman in the following text incorporates the changes proposed by the preceding text.

only), in addition to the sums allotted to it for such purpose for each of such next two fiscal years.

[(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this part be added to the allotment of another State under this part for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health center in such other State. If it is found by the Secretary that construction of the center with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment as requested by it, would assist in carrying out the purposes of this part, such portion of such State's allotment shall be added to the allotment of the other State under this part to be used for the purpose referred to above.

[(c) Upon the request of any State that a specified portion of its allotment under this part be added to the allotment of such State under part C of title I and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this part to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such portion or (2) a showing satisfactory to the Secretary that the need for facilities for the mentally retarded in such State is substantially greater than for community mental health centers, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under part C of title I, and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this part and part C of title I.

REGULATIONS

[SEC. 203. Within six months after enactment of this Act, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act) and the National Advisory Mental Health Council (established by section 217 of the Public Health Service Act), by general regulations applicable uniformly to all the States, prescribe—

[(1) the kinds of community mental health services needed to provide adequate mental health services for persons residing in a State;

[(2) the general manner in which the State agency (designated as provided in the State plan approved under this part) shall determine the priority of projects based on the relative need of different areas, giving special consideration to projects on the basis of the extent to which the centers to be constructed thereby will, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, provide comprehensive mental health services (as determined by the Secretary in accordance with regulations) for men-

tally ill persons in a particular community or communities or which will be part of or closely associated with a general hospital;

[(3) general standards of construction and equipment for centers of different classes and in different types of location; and

[(4) that the State plan shall provide for adequate community mental health centers for people residing in the State, and shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor. Such regulations may require that before approval of an application for a center or addition to a center is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such center or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

[STATE PLANS

[SEC. 204. (a) After such regulations have been issued, any State desiring to take advantage of this part shall submit a State plan for carrying out its purposes. Such State plan must—

[(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

[(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this part;

[(3) provide for the designation of a State advisory council which shall include representatives of non-government organizations or groups, and of State agencies, concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, including representatives of consumers of the services provided by such centers and facilities who are familiar with the need for such services, to consult with the State agency in carrying out such plan;

[(4) set forth a program for construction of community mental health centers (A) which is based on a statewide inventory of existing facilities and survey of need; (B) which conforms with the regulations prescribed by the Secretary under section 203(1); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 203(4);

[(5) set forth the relative need, determined in accordance with the regulations prescribed under section 203(2), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

[(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection,

tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

[(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this part and, effective July 1, 1969, provide for enforcement of such standards with respect to projects approved by the Secretary under this part after June 30, 1967;

[(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

[(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

[(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

[(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

[(c) After June 30, 1973, the Secretary may not approve any State plan unless it provides for treatment and prevention programs in the field of drug abuse and drug dependence, commensurate with the extent of the problem, and it includes the provisions required by section 314(d)(2)(K) of the Public Health Service Act for State plans submitted under section 314(d) of such Act.

[(APPROVAL OF PROJECTS

[SEC. 205. (a) For each project for construction pursuant to a State plan approved under this part, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

[(1) a description of the site for such project;

[(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 203(3);

[(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the community mental health center;

[(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

[(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates

not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a-5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z-15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

[(6) a certification by the State agency of the Federal share for the project.

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages and overtime pay; (B) that the plans and specifications are in accord with the regulations prescribed pursuant to section 203; (C) that the application is in conformity with the State plan approved under section 204 and contains an assurance that in the operation of the center there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 203(4) for furnishing needed services for persons unable to pay therefor, and with State standards for operation and maintenance; (D) that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated, at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations; and (E) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203(2). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

[(b) Amendment of any approved application shall be subject to approval in the same manner as an original application.

[WITHHOLDING OF PAYMENTS

[Sec. 206. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 204(a) (1), finds—

[(1) that the State agency is not complying substantially with the provisions required by section 204 to be included in its State plan, or with regulations under this part;

[(2) that any assurance required to be given in an application filed under section 205 is not being or cannot be carried out;

[(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 205; or

[(4) that adequate State funds are not being provided annually for the direct administration of the State plan, the Secretary may forthwith notify the State agency that—

[(5) no further payments will be made to the State from allotments under this part; or

[(6) no further payments will be made from allotments under this part for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section, as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

[NONDUPLICATION OF GRANTS

[SEC. 207. No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the fiscal years in the period beginning July 1, 1964, and ending June 30, 1975, for construction of any facility described in this title, unless the Secretary determines that funds are not available, under this title to make a grant for the construction of such facility.

[PART B—GRANTS FOR INITIAL COST OF PROFESSIONAL AND TECHNICAL PERSONNEL OF CENTERS

[AUTHORIZATION, DURATION, AND AMOUNT OF GRANTS

[SEC. 220. (a) For the purpose of assisting in the establishment and initial operation of community mental health centers providing all or part of a comprehensive community mental health program, the Secretary may, in accordance with the provisions of this part, make grants to meet, for the temporary periods specified in this section, a portion of the costs (determined pursuant to regulations under section 223) of compensation of professional and technical personnel for the initial operation of new community mental health centers or of new services in community mental health centers.

[(b) (1) Grants under this section for such costs for any center may be made only for the period beginning with the first day of the first month for which such a grant is made and ending with the close of eight years after such first day; and, except as provided in paragraph (2), such grants with respect to any center may not exceed 75 per centum of such costs for each of the first two years after such first day, 60 per centum of such costs for the third year after such first day, 45 per centum of such costs for the fourth year after such first day, and 30 per centum of such costs for each of the next four years after such first day.

[(2) In the case of any such center providing services for persons in an area designated by the Secretary as an urban or rural poverty area, grants under this section for such costs for any such center may not exceed 90 per centum of such costs for each of the first two years after such first day, 80 per centum of such costs for the third year after such first day, 75 per centum of such costs for the fourth and fifth years after such first day, and 70 per centum of such costs for each of the next three years after such first day.

[(c) In making such grants, the Secretary shall take into account the relative needs of the several States for community mental health center programs, their relative financial needs, and their populations.

[APPLICATIONS AND CONDITIONS FOR APPROVAL

[SEC. 221. (a) Grants under this part with respect to any community mental health center may be made only upon application, and only if—

[(1) the applicant is a public or nonprofit private agency or organization which owns or operates the center;

[(2) the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is situated, at least those essential elements of comprehensive mental health services which are prescribed by the Secretary;

[(3) (A) a grant was made under part A of this title to assist in financing the construction of the center or (B) the type of service to be provided as part of such program with the aid of a grant under this part was not previously being provided by the center with respect to which such application is made;

[(4) the Secretary determines that there is satisfactory assurance that (A) the services to be provided will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) in, services that would otherwise be provided, and (B) Federal funds made available under this part for any period will be so used as to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third party health insurance payments, that would be in the absence of such Federal funds be made available for the program described in paragraph (2) of this subsection and will in no event supplant such State, local, and other non-Federal funds; and

[(5) the services to be provided by the center are described in the State mental health plan submitted to the Public Health Service by the State mental health authority in accordance with title III of the Public Health Service Act.

[Notwithstanding the provisions of paragraph (2) of this subsection, the requirement therein with respect to essential elements of comprehensive mental health services shall not apply, in the case of an application for a grant to any center which will provide services in an area designated by the Secretary as an urban or rural poverty area,

for the eighteen-month period commencing on the date such application is filed, if the Secretary is satisfied that such center will meet such requirement prior to the end of such period; however, if such center has not by the end of such eighteen-month period met such requirement, payments under any grant (made under such application) to such center shall be suspended until the Secretary determines that the center has met such requirement.

[(b) No grant may be made under this part after June 30, 1975, with respect to any community mental health center or with respect to any type of service provided by such a center unless a grant with respect thereto was made under this part prior to July 1, 1975.

[(c) If an application for a grant under this part for a community mental health center is made for any fiscal year beginning after June 30, 1972, and—

[(1) the Secretary determines that it is feasible for such center to provide a treatment and rehabilitation program for drug addicts and other persons with drug abuse and other drug dependence problems residing in the area served by the center and that the need for such a program in that area is of such a magnitude as to warrant the provision of such a program by the center, such application may not be approved unless it contains or is supported by assurances satisfactory to the Secretary that the center will provide such program in such fiscal year; or

[(2) the Secretary determines that it is feasible for the center to assist the Federal Government in treatment and rehabilitation programs for drug addicts and other persons with drug abuse and other drug dependence problems who are in the area served by the center, such application may not be approved unless it contains or is supported by assurances satisfactory to the Secretary that the center will enter into agreements with departments or agencies of the Government under which agreements the center may be used (to the maximum extent practicable) in treatment and rehabilitation programs (if any) provided by such departments or agencies.

For the purpose of making grants under this part to assist community mental health centers to meet the requirements of this subsection there are authorized to be appropriated \$60,000,000 for fiscal year ending June 30, 1973, \$60,000,000 for the fiscal year ending June 30, 1974, and \$60,000,000 for the fiscal year ending June 30, 1975.

[PAYMENTS

[SEC. 222. Payment of grants under this part may be made (after necessary adjustment on account of previously made overpayments or underpayments) in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

[REGULATIONS

[SEC. 223. The Secretary shall, after consultation with the National Advisory Mental Health Council (appointed pursuant to the Public Health Service Act), prescribe general regulations concerning eligi-

bility of centers under this part, determination of eligible costs with respect to which grants may be made, and the terms and conditions (including those specified in section 221) for approving applications under this part.

【AUTHORIZATION OF APPROPRIATIONS

【SEC. 224. (a) There are hereby authorized to be appropriated \$19,500,000 for the fiscal year ending June 30, 1966, \$24,000,000 for the fiscal year ending June 30, 1967, \$30,000,000 for the fiscal year ending June 30, 1968, \$26,000,000 for the fiscal year ending June 30, 1969, \$32,000,000 for the fiscal year ending June 30, 1970, \$45,000,000 for the fiscal year ending June 30, 1971, \$50,000,000 for the fiscal year ending June 30, 1972, \$60,000,000 for the fiscal year ending June 30, 1973, and \$49,131,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, to enable the Secretary to make initial grants to community mental health centers under the provisions of this part. For the fiscal year ending June 30, 1967, and each of the fourteen succeeding years, there are hereby authorized to be appropriated such sums as may be necessary to make grants to such centers which have previously received a grant under this part and are eligible for such a grant for the year for which sums are being appropriated under this sentence.

【(b) Not to exceed 5 per centum of the amount appropriated for grants pursuant to subsection (a) for any fiscal year shall be available to the Secretary to make grants to local public or nonprofit private organizations to cover up to 100 per centum of the costs (but in no case to exceed \$50,000) of projects, in areas designated by the Secretary as rural or urban poverty areas, for assessing local needs for mental health services, designing mental health service programs, obtaining local financial and professional assistance and support for community health services, and fostering community involvement in initiating and developing community mental health services. In no case shall a grant under this subsection be for a period in excess of one year; nor shall any grant be made under this subsection with respect to any project if, for any preceding year, a grant under this subsection has been made with respect to such project.

【PART C—ALCOHOLISM

【DECLARATION OF FINDINGS AND PURPOSES

【SEC. 240. (a) The Congress hereby finds that—

【(1) Alcoholism is a major health and social problem afflicting a significant proportion of the public, and much more needs to be done by public and private agencies to develop effective prevention and control.

【(2) Alcoholism treatment and control programs should whenever possible: (A) be community based, (B) provide a comprehensive range of services, including emergency treatment, under proper medical auspices on a coordinated basis, and (C) be integrated with and involve the active participation of a wide range of public and nongovernmental agencies.

【(3) The handling of chronic alcoholics within the system of criminal justice perpetuates and aggravates the broad problem of alcohol-

ism whereas treating it as a health problem permits early detection and prevention of alcoholism and effective treatment and rehabilitation, relieves police and other law enforcement agencies of an inappropriate burden that impedes their important work, and better serves the interests of the public.

[(b) It is the purpose of this part to help prevent and control alcoholism through authorization of Federal aid in the construction and staffing of facilities for the prevention and treatment of alcoholism.

[(c) The Congress further declares that, in addition to the funds provided for under this part, other Federal legislation providing for Federal or federally assisted research, prevention, treatment, or rehabilitation programs in the fields of health should be utilized to help eradicate alcoholism as a major health program.

CONSTRUCTION GRANTS

[SEC. 241. (a) Grants from appropriations under section 261 may be made for projects for construction of any facilities (including post-hospitalization treatment facilities) for the prevention and treatment of alcoholism, but only to a public or nonprofit private agency or organization and only upon an application (1) which meets the requirements for approval under clauses (1) through (5) and clauses (A) and (B) of section 205(a), and (2) which contains—

[(A) a showing of the need, in the area to be served by the applicant, for special facilities for the inpatient or outpatient treatment, or both, of alcoholism;

[(B) satisfactory assurance that the services for prevention and treatment of alcoholism to be provided through the facility to be constructed, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated or having an arrangement with the applicant, will be part of a program providing, principally for persons residing in or near the particular community or communities in which such facility is situated, at least those essential elements of comprehensive mental health services and services for the prevention and treatment of alcoholism, including post-institutional aftercare and rehabilitation, that are prescribed by the Secretary;

[(C) satisfactory assurance that the application has been approved and recommended by the single State agency designated by the State as being the agency primarily responsible for care and treatment of alcoholics in the State, and, in case this agency is different from the agency designated pursuant to section 204(a) (1), a showing that the application has also been approved and recommended by the agency designated pursuant to section 204(a) (1), and, in case neither of these is the State mental health authority, a showing that the application has been approved and recommended by such authority;

[(D) a showing that under regulations of the Secretary prescribing the manner of determining priorities the project is entitled to priority over other projects for treatment of alcoholism, if any, within the State, and is in accordance with such criteria, including the willingness and ability to provide satisfactory alter-

natives to custodial care, as the Secretary may determine to be appropriate for purposes of this section; and

[(E) a showing that adequate provision has been made for compliance with regulations of the Secretary prescribed under section 203(4) relating to furnishing needed services for persons unable to pay therefor and for compliance with State standards for operation and maintenance.

[(b) The amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66 $\frac{2}{3}$ per centum (or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area) as the Secretary may determine.

[STAFFING GRANTS

[SEC. 242. (a) Grants from appropriations under section 261 may be made to any public or nonprofit private agency or organization to assist it in meeting, for the temporary periods specified in this section, a portion of the costs (determined pursuant to regulations of the Secretary) of compensation of professional and technical personnel for the initial operation of new facilities for the prevention and treatment of alcoholism or of new services in existing facilities for the prevention or treatment of alcoholism.

[(b)(1) Grants under this part for such costs for any facility may be made only for the period beginning with the first day of the first month for which such a grant is made and ending with the close of eight years after such first day; and, except as provided in paragraph (2), such grants with respect to any facility may not exceed 80 per centum of such costs for each of the first two years after such first day, 75 per centum of such costs for the third year after such first day, 60 per centum of such costs for the fourth year after such first day, 45 per centum of such costs for the fifth year after such first day, and 30 per centum of such costs for each of the next three years after such first day.

[(2) In the case of any such facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area, such grants with respect to any such facility may not exceed 90 per centum of such costs for each of the first two years after such first day, 80 per centum of such costs for the third year after such first day, 75 per centum of such costs for the fourth and fifth years after such first day, and 70 per centum of such costs for each of the next three years after such first day.

[(c) In making such grants, the Secretary shall take into account the relative needs of the several States for alcoholism programs, the relative financial needs of the applicants, and the relative populations of the areas to be served by the applicants.

[(d) A grant under this section may be made only upon an application which meets the requirements for approval under section 221(a), other than paragraph (3) thereof, and only if (1) a grant was made under part A or section 241 to assist in financing the construction of the facility, or (2) the type of service to be provided with the aid

of a grant under this section was not previously being provided by the facility with respect to which such application is made.

【SPECIALIZED FACILITIES

【SEC. 243. (a) Grants from appropriations under section 261 may also be made to public or nonprofit private agencies or organizations for projects for the construction or leasing of specialized facilities (including facilities for emergency medical services, intermediate care services, or outpatient services, and post-hospitalization treatment facilities) for the treatment of alcoholics requiring care in such facilities, and for the costs, determined pursuant to regulations of the Secretary, of compensation of professional and technical personnel for the initial operation of such facilities constructed with grants made under part A of this section or of new services in existing specialized facilities for the treatment of alcoholics.

【(b) Grants may be made under subsection (a) only with respect to (1) facilities which are a part of or affiliated with a community mental health center providing at least those essential elements of comprehensive community mental health services which are prescribed by the Secretary, or (2) where there is no such center serving the community in which such facilities are to be situated, facilities with respect to which satisfactory provision (as determined by the Secretary) has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of alcoholism.

【(c) Grants under the subsection (a) for the costs of compensation of professional and technical personnel may not exceed the percentages of such costs, and may be made only for the periods, prescribed for grants for such costs under section 242.

【(d) Before a grant may be made under subsection (a) for a project for the construction of a facility for the treatment of alcoholics the Secretary must find that the application for such grant meets the requirement of section 205(a)(5) (relating to the payment of prevailing wages). The amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66 $\frac{2}{3}$ per centum (or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area), as the Secretary may determine.

【PROJECTS ELIGIBLE UNDER REGULAR PROGRAM

【SEC. 244. Nothing in this part shall be construed to preclude approval under part A or B of a grant for a project for the construction or initial staffing of a facility for the prevention and treatment of alcoholism.

【PAYMENTS

【SEC. 245. Payments of grants under this part may be made in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

[DIRECT GRANTS FOR SPECIAL PROJECTS

[SEC. 246. The Secretary is authorized during the period beginning July 1, 1970, and ending June 30, 1975, to make grants to any public or nonprofit private agency or organization to cover part or all of the cost of (1) developing specialized training programs or materials relating to the provision of public health services for the prevention or treatment of alcoholism, or developing in-service training or short-term or refresher courses with respect to the provision of such services; (2) training personnel to operate, supervise, and administer such services; (3) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of alcoholism within the several States with a view to determining ways and means of improving, extending, and expanding such programs; and (4) programs for treatment and rehabilitation of alcoholics which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such alcoholics.

[GRANTS AND CONTRACTS FOR THE PREVENTION AND TREATMENT OF ALCOHOL ABUSE AND ALCOHOLISM

[SEC. 247. (a) The Secretary, acting through the National Institute on Alcohol Abuse and Alcoholism, may make grants to public and private nonprofit agencies, organizations, and institutions and may enter into contracts with public and private agencies, organizations, and institutions, and individuals—

[(1) to conduct demonstration, service, and evaluation projects,

[(2) to provide education and training.

[(3) to provide programs and services in cooperation with schools, courts, penal institutions, and other public agencies, and

[(4) to provide counseling and education activities on an individual or community basis,

for the prevention and treatment of alcohol abuse and alcoholism and for the rehabilitation of alcohol abusers and alcoholics.

[(b) Projects for which grants or contracts are made under this section shall, whenever possible, be community based, provide a comprehensive range of services, and be integrated with, and involve the active participation of, a wide range of public and nongovernmental agencies, organizations, institutions, and individuals.

[(c) (1) In administering the provisions of this section, the Secretary shall require coordination of all applications for programs in a State.

[(2) Each applicant from within a State, upon filing its application with the Secretary for a grant or contract under this section, shall submit a copy of its application for review by the State agency designated under section 303 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, if such agency exists. Such State agency shall be given not more than thirty days from the date of receipt of the application to submit to the Secretary, in writing, an evaluation of the project set forth in the application. Such evaluation shall include comments on the relation-

ship of the project to other projects pending and approved and to the State comprehensive plan for treatment and prevention of alcohol abuse and alcoholism under such section 303. The State shall furnish the applicant a copy of any such evaluation.

[(3) Approval of any application for a grant or contract by the Secretary, including the earmarking of financial assistance for a program or project, may be granted, only if the application substantially meets a set of criteria established by the Secretary that—

[(A) provide that the activities and services for which assistance under this section is sought will be substantially administered by or under the supervision of the applicant;

[(B) provide for such methods of administration as are necessary for the proper and efficient operation of such programs or projects;

[(C) provide such fiscal control and fund accounting procedures as may be necessary to assure proper disbursement of and accounting for Federal funds paid to the applicant; and

[(D) provide reasonable assurance that Federal funds made available under this section for any period will be so used as to supplement and increase, to the extent feasible and practical, the level of State, local, and other non-Federal funds that would in the absence of such Federal funds be made available for the programs described in this section, and will in no event supplant such State, local, and other non-Federal funds.

[(d) To carry out the purposes of this section, there are authorized to be appropriated \$30,000,000 for the fiscal year ending June 30, 1971, \$40,000,000 for the fiscal year ending June 30, 1972, and \$50,000,000 for each of the fiscal years ending June 30, 1973, June 30, 1974, and June 30, 1975.

[PART D—NARCOTIC ADDICTION, DRUG ABUSE, AND DRUG DEPENDENCE PREVENTION AND REHABILITATION

[SEC. 251. (a) Grants from appropriations under section 261 may be made to public or nonprofit private agencies and organizations to assist them in meeting the costs of construction or leasing of treatment facilities (including facilities for emergency medical services, intermediate care services, or outpatient services, or post-hospitalization treatment facilities) for narcotic addicts and other persons with drug abuse and drug dependence problems within the States, and to assist them in meeting the costs, determined pursuant to regulations of the Secretary, of compensation of professional and technical personnel for the initial operation of such facilities constructed or leased with grants made under part A or this part or of new services in existing treatment facilities for narcotic addicts, and other persons with drug abuse and drug dependence problems.

[(b) The grant program for construction or leasing of facilities authorized by subsection (a) shall be carried out consistently with the grant program under part A except to the extent, in the judgment of the Secretary, special considerations make differences appropriate; but (1) before the Secretary may make a grant under such subsection for the construction of a treatment facility for narcotic addicts and other

persons with drug abuse and drug dependence problems he must find that the application for such grant meets the requirement of section 205(a)(5) (relating to the payment of prevailing wages), and (2) the amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66⅔ per centum (or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area) ; as the Secretary may determine.

[(c) Grants made under subsection (a) for the costs of compensation of professional and technical personnel may not exceed the percentages of such costs, and may be made only for the periods, prescribed for grants for such costs under section 242.

[DIRECT GRANTS FOR SPECIAL PROJECTS

[SEC. 252. The Secretary is authorized, during the period beginning July 1, 1968, and ending with the close of June 30, 1975, to make grants to any public or nonprofit private agencies and organizations to cover part or all of the cost of (A) developing specialized training programs or materials relating to the provision of public health services for the prevention and treatment of narcotic addiction, drug abuse, and drug dependence or developing in-service training or short-term or refresher courses with respect to the provision of such services; (B) training personnel to operate, supervise, and administer such services; (C) conducting surveys and field trials to evaluate the adequacy of the programs for the prevention and treatment of narcotic addiction, drug abuse, and drug dependence within the several States with a view to determining ways and means of improving, extending, and expanding such programs; and (D) programs for treatment and rehabilitation of narcotic addicts and other persons with drug abuse and drug dependence problems which the Secretary determines are of special significance because they demonstrate new or relatively effective or efficient methods of delivery of services to such narcotic addicts and other persons with drug abuse and drug dependence problems.

[DRUG ABUSE EDUCATION

[SEC. 253. (a) The Secretary is authorized to make grants to States and political subdivisions thereof and to public or nonprofit private agencies and organizations, and to enter into contracts with other private agencies and organizations, for—

[(1) the collection, preparation, and dissemination of educational materials dealing with the use and abuse of drugs and the prevention of drug abuse, and

[(2) the development and evaluation of programs of drug abuse education directed at the general public, school-age children, and special high-risk groups.

[(b) The Secretary, acting through the National Institute of Mental Health, shall (1) serve as a focal point for the collection and dissemination of information related to drug abuse; (2) collect, prepare, and disseminate materials (including films and other educational devices) dealing with the abuse of drugs and the prevention of drug

abuse; (3) provide for the preparation, production, and conduct of programs of public education (including those using films and other educational devices); (4) train professional and other persons to organize and participate in programs of public education in relation to drug abuse; (5) coordinate activities carried on by such departments, agencies, and instrumentalities of the Federal Government as he shall designate with respect to health education aspects of drug abuse; (6) provide technical assistance to State and local health and educational agencies with respect to the establishment and implementation of programs and procedures for public education on drug abuse; and (7) undertake other activities essential to a national program for drug abuse education.

[(c) The Secretary, acting through the National Institute of Mental Health, is authorized to develop and conduct workshops, institutes, and other activities for the training of professional and other personnel to work in the area of drug abuse education.

[(d) To carry out the purposes of this section, there are authorized to be appropriated \$3,000,000 for the fiscal year ending June 30, 1971, \$12,000,000 for the fiscal year ending June 30, 1972, \$14,000,000 for the fiscal year ending June 30, 1973, and \$1,700,000 each for the fiscal years ending June 30, 1974, and June 30, 1975.

[PROJECTS ELIGIBLE UNDER REGULAR PROGRAM

[SEC. 254. Nothing in this part shall be construed to preclude approval under part A or B of a grant for a project for the construction or initial staffing of a facility for the treatment of narcotic addicts, and other persons with drug abuse and drug dependence problems.

[PAYMENTS

[SEC. 255. Payments under this part may be made in advance or by way of reimbursement, and on such terms and conditions and in such installments, as the Secretary may determine.

[SPECIAL PROJECTS FOR NARCOTIC ADDICTS AND DRUG DEPENDENT PERSONS

[SEC. 256. (a) The Secretary is authorized to make grants to public or nonprofit private agencies and organizations to cover a portion of the costs of programs for treatment and rehabilitation of narcotic addicts or drug dependent persons which include one or more of the following: (1) Detoxification services or (2) institutional services (including medical, psychological, educational, or counseling services) or (3) community-based aftercare services.

[(b) Grants under this section for the costs of any treatment and rehabilitation program—

[(1) may be made only for the period beginning with the first day of the first month for which such a grant is made and ending with the close of eight years after such first day; and

[(2) (A) except as provided in subparagraph (B), may not exceed 80 per centum of such costs for each of the first two years after such first day, 75 per centum of such costs for the third year

after such first day, 60 per centum of such costs for the fourth year after such first day, 45 per centum of such costs for the fifth year after such first day, and 30 per centum of such costs for each of the next three years after such first day; and

[(B) in the case of any such program providing services for persons in an area designated by the Secretary as an urban or rural poverty area, such grants may not exceed 90 per centum of such costs for each of the first two years after such first day, 80 per centum of such costs for the third year after such first day, 75 per centum of such costs for the fourth and fifth years after such first day, and 70 per centum of such costs for each of the next three years after such first day.

[(c) No application for a grant authorized by this section shall be approved by the Secretary unless such application is forwarded through the State agency responsible for administering the plan submitted pursuant to section 204 of this Act or, if there be a separate State agency, designated by the Governor as responsible for planning, coordinating, and executing the State's efforts in the treatment and rehabilitation of narcotic addicts and drug dependent persons, through such latter agency, which shall submit to the Secretary such comments as it deems appropriate. No application for a grant under this section for a program to provide services for persons in an area in which is located a facility constructed as a new facility after the date of enactment of this section with funds provided under a grant under part A of this part shall be approved unless such application contains satisfactory assurance that, to the extent feasible, such program will be included as part of the programs conducted in or through such facility.

[(d) The Secretary shall make grants under this section for projects within the States in accordance with criteria determined by him designed to provide priority for grant applications in States, and in areas within the States, having the higher percentages of population who are narcotic addicts or drug dependent persons.

[(e) There are authorized to be appropriated to carry out this section not to exceed \$20,000,000 for the fiscal year ending June 30, 1971; \$30,000,000 for the fiscal year ending June 30, 1972; \$60,000,000 for the fiscal year ending June 30, 1973; and \$60,000,000 each for the fiscal years ending June 30, 1974, and June 30, 1975.

[(PART E—GENERAL PROVISIONS

[(AUTHORIZATION OF APPROPRIATIONS FOR REHABILITATION OF ALCOHOLICS, NARCOTIC ADDICTS, AND OTHER PERSONS WITH DRUG ABUSE AND DRUG DEPENDENCE PROBLEMS

[(SEC. 261. (a) There are authorized to be appropriated \$15,000,000 for the fiscal year ending June 30, 1969, \$15,000,000 for the fiscal year ending June 30, 1970, \$40,000,000 for the fiscal year ending June 30, 1971, \$60,000,000 for the fiscal year ending June 30, 1972, and \$80,000,000 for the fiscal year ending June 30, 1973, and \$36,774,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, for project grants for construction and staffing of facilities for the prevention and treatment of alcoholism under part C or the prevention and treatment of narcotic addiction, drug abuse, and drug dependence under part

D and for grants under section 252 and section 246. Sums so appropriated for any fiscal year shall remain available for obligation until the close of the next fiscal year.

[(b) There are also authorized to be appropriated for the fiscal year ending June 30, 1971, and each of the next ten fiscal years such sums as may be necessary to continue to make grants for staffing with respect to any project under part C or D for which a staffing grant was made from appropriations under subsection (a) of this section for any fiscal year ending before July 1, 1975.

[(c) Not to exceed 5 per centum of the amount appropriated pursuant to the preceding provisions of this section for any fiscal year shall be available to the Secretary to make grants to local public or nonprofit private organizations to cover up to 100 per centum of the costs (but in no case to exceed \$50,000) of projects for assessing local needs for programs of services for alcoholics or narcotic addicts, and other persons with drug abuse and drug dependence problems designing such programs, obtaining local financial and professional assistance and support for such programs in the community, and fostering community involvement in initiating and developing such programs in the community. In no case shall a grant under this subsection be for a period in excess of one year; nor shall any grant be made under this subsection with respect to any project if, for any preceding year, a grant under this subsection has been made with respect to such project.

[PROTECTION OF PERSONAL RIGHTS OF ALCOHOLICS, NARCOTIC ADDICTS, AND OTHER PERSONS WITH DRUG ABUSE AND DRUG DEPENDENCE PROBLEMS]

[SEC. 263. In making grants to carry out the purposes of parts C and D, the Secretary shall take such steps as may be necessary to assure that no individual shall be made the subject of any research which is carried out (in whole or in part) with funds provided from appropriations under this part unless such individual explicitly agrees to become a subject of such research.

[GRANTS FOR CONSULTATION SERVICES]

[SEC. 264. (a) In the case of any community mental health center, alcoholism prevention and treatment facility, specialized facility for alcoholics, treatment facility for narcotic addicts, and other persons with drug abuse and drug dependence problems, or facility for mental health of children, to which a grant under part B, C, D, or F, as the case may be, is made from appropriations for any fiscal year beginning after June 30, 1970, to assist it in meeting a portion of the costs of compensation of professional and technical personnel who provide consultation services, the Secretary may, with respect to such center or facility, make a grant under this section in addition to such other staffing grant for such center or facility.

[(b) A grant under subsection (a) with respect to a center or facility referred to in that subsection—

[(1) may be made only for the period applicable to the staffing grant made under part B, C, D, or F, as the case may be, with respect to such center or facility, and

[(2) may not exceed whichever of the following is the lower:
(A) 15 per centum of the costs with respect to which such other

staffing grant is made, or (B) that percentage of such costs which when added to the percentage of such costs covered by such other staffing grant equals 100 per centum.

[(c) For purposes of making initial grants under this section, there are authorized to be appropriated \$5,000,000 for each of the fiscal years ending June 30, 1971, June 30, 1972, and June 30, 1973. There are also authorized to be appropriated for the fiscal year ending June 30, 1972, and for each of the next eight fiscal years such sums as may be necessary to continue to make grants under this section for projects which received initial grants under this section from appropriations authorized for any fiscal year ending before July 1, 1973.

[DEFINITION OF TECHNICAL PERSONNEL

[SEC. 265. For purposes of this title, the term "technical personnel" includes accountants, financial counselors, medical transcribers, allied health professions personnel, dietary and culinary personnel, and any other personnel whose background and education would indicate that they are to perform technical functions in the operation of centers or facilities for which assistance is provided under this title; but such term does not include minor clerical personnel or maintenance or housekeeping personnel.

[APPROVAL BY NATIONAL ADVISORY MENTAL HEALTH COUNCIL

[SEC. 266. Grants made under this title (other than parts C and D thereof) for the cost of construction and for the cost of compensation of professional and technical personnel may be made only upon recommendation of the National Advisory Mental Health Council established by section 217(a) of the Public Health Service Act. Grants under part C of this title for such costs may be made only upon recommendation of the National Advisory Council on Alcohol Abuse and Alcoholism. Grants under part D of this title for such costs will undergo such review as is provided by section 217(e) of the Public Health Service Act.

[PART F—MENTAL HEALTH OF CHILDREN

[GRANTS FOR TREATMENT FACILITIES

[SEC. 271. (a) Grants from appropriations under section 272(a) may be made to public or nonprofit private agencies and organizations (1) to assist them in meeting the costs of construction of facilities to provide mental health services for children within the States, and (2) to assist them in meeting a portion of the costs (determined pursuant to regulations of the Secretary) of compensation of professional and technical personnel for the operation of a facility for mental health of children constructed with a grant made under part A or this part or for the operation of new services for mental health of children in an existing facility.

[(b) (1) Grants may be made under this section only with respect to (A) facilities which are part of or affiliated with a community mental health center providing at least those essential services which are prescribed by the Secretary, or (B) where there is no such center

serving the community in which such facilities are to be situated; facilities with respect to which satisfactory provision (as determined by the Secretary) has been made for appropriate utilization of existing community resources needed for an adequate program of prevention and treatment of mental health problems of children.

[(2) No grant shall be made under this section with respect to any facility unless the applicant for such grant provides assurances satisfactory to the Secretary that such facility will make available a full range of treatment, liaison, and follow-up, services (as prescribed by the Secretary) for all children and their families in the service area of such facility who need such services, and will, when so requested, provide consultation and education for personnel of all schools and other community agencies serving children in such area.

[(3) The grant program for construction of facilities authorized by subsection (a) shall be carried out consistently with the grant program under part A, except that the amount of any such grant with respect to any project shall be such percentage of the cost thereof, but not in excess of 66⅔ per centum (or 90 per centum in the case of a facility providing services for persons in an area designated by the Secretary as an urban or rural poverty area), as the Secretary may determine.

[(c) Grants made under this section for costs of compensation of professional and technical personnel may not exceed the percentages of such costs, and may be made only for the periods, prescribed for grants for such costs under section 242.

[(d) (1) There are authorized to be appropriated \$12,000,000 for the fiscal year ending June 30, 1971, \$20,000,000 for the fiscal year ending June 30, 1972, and \$30,000,000 for the fiscal year ending June 30, 1973, and \$16,515,000 each for the fiscal years ending June 30, 1974, and June 30, 1975, for grants under this part for construction and for initial grants under this part for compensation of professional and technical personnel, and for training and evaluation grants under section 272.

[(2) There are also authorized to be appropriated for the fiscal year ending June 30, 1972, and each of the next nine fiscal years such sums as may be necessary to continue to make grants with respect to any project under this part for which an initial staffing grant was made from appropriations under paragraph (1) for any fiscal year ending before July 1, 1975.

TRAINING AND EVALUATION

[SEC. 272. The Secretary is authorized, during the period beginning July 1, 1971, and ending with the close of June 30, 1973, to make grants to public or nonprofit private agencies or organizations to cover part or all of the cost of (1) developing specialized training programs or materials relating to the provision of services for the mental health of children, or developing inservice training or short-term or refresher courses with respect to the provisions of such services; (2) training personnel to operate, supervise, and administer such services; and (3) conducting surveys and field trials to evaluate the adequacy of the programs for the mental health of children within the several States with a view to determining ways and means of improving, extending, and expanding such programs.]

TITLE II—COMMUNITY MENTAL HEALTH CENTERS

PART A—PLANNING AND OPERATIONS ASSISTANCE

REQUIREMENTS FOR COMMUNITY MENTAL HEALTH CENTERS

SEC. 201. (a) For purposes of this title (other than part B thereof), the term "community mental health center" means a legal entity (1) through which comprehensive mental health services are provided—

(A) principally to individuals residing in a defined geographic area (referred to in this title as a "catchment area"),

(B) within the limits of its capacity, to any individual residing or employed in such area regardless of his ability to pay for such services, his current or past health condition, or any other factor, and

(C) in the manner prescribed by subsection (b), and (2) which is organized in the manner prescribed by subsections (c) and (d).

(b)(1) The comprehensive mental health services which shall be provided through a community mental health center shall include—

(A) inpatient services, outpatient services, day care and other partial hospitalization services, and emergency services;

(B) a program of specialized services for the mental health of children, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

(C) a program of specialized services for the mental health of the elderly, including a full range of diagnostic, treatment, liaison, and followup services (as prescribed by the Secretary);

(D) consultation and education services which—

(i) are for a wide range of individuals and entities involved with mental health services, including health professionals, schools, courts, State and local law enforcement and correctional agencies, members of the clergy, public welfare agencies, health services delivery agencies, and other appropriate entities; and

(ii) include a wide range of activities (other than the provision of direct clinical services) designed to (I) develop effective mental health programs in the center's catchment area, (II) promote the coordination of the provision of mental health services among various entities serving the center's catchment area, (III) increase the awareness of the residents of the center's catchment area of the nature of mental health problems and the types of mental health services available, and (IV) promote the prevention and control of rape and the proper treatment of the victims of rape;

(E) assistance to courts and other public agencies in screening residents of the center's catchment area who are being considered

for referral to a State mental health facility for inpatient treatment to determine if they should be so referred and provision, where appropriate, of treatment for such persons through the center as an alternative to inpatient treatment at such a facility:

(F) provision of followup care for residents of its catchment area who have been discharged from a mental health facility;

(G) a program of transitional half-way house services for mentally ill individuals who are residents of its catchment area and who have been discharged from a mental health facility or would without such services require inpatient care in such a facility; and

(H) provision of each of the following service programs (other than a service program for which there is not sufficient need (as determined by the Secretary) in the center's catchment area, or the need for which in the center's catchment area the Secretary determines is currently being met):

(i) A program for the prevention and treatment of alcoholism and alcohol abuse and for the rehabilitation of alcohol abusers and alcoholics.

(ii) A program for the prevention and treatment of drug addiction and abuse and for the rehabilitation of drug addicts, drug abusers, and other persons with drug dependency problems.

(2) The provision of comprehensive mental health services through a center shall be coordinated with the provision of services by other health and social service agencies (including State mental health facilities) in or serving residents of the center's catchment area to insure that persons needing or receiving services through the center have access to all such health and social services as they may require. The center's services (A) may be provided at the center or satellite centers through the staff of the center or through appropriate arrangements with health professionals and others in the center's catchment area, (B) shall be available and accessible to the residents of the area promptly, as appropriate, and in a manner which preserves human dignity and assures continuity and high quality care and which overcomes geographic, cultural, linguistic, and economic barriers to the receipt of services, and (C) when medically necessary, shall be available and accessible twenty-four hours a day and seven days a week.

(c)(1)(A) The governing body of a community mental health center (other than a center described in subparagraph (B)) shall (i) be composed, where practicable, of individuals who reside in the center's catchment area and who, as a group, represent the residents of that area taking into consideration their employment, age, sex, and place of residence, and other demographic characteristics of the area, and (ii) meet at least once a month, establish general policies for the center (including a schedule of hours during which services will be provided), approve the center's annual budget, and approve the selection of a director for the center. At least one-half of the members of such body shall be individuals who are not providers of health care.

(B) In the case of a community mental health center which before the date of enactment of the Community Mental Health Centers Amendments of 1975 was operated by a governmental agency and

received a grant under section 220 (as in effect before such date), the requirements of subparagraph (A) shall not apply with respect to such center, but the governmental agency operating the center shall appoint a committee to advise it with respect to the operations of the center, which committee shall be composed of individuals who reside in the center's catchment area, who are representative of the residents of the area as to employment, age, sex, place of residence, and other demographic characteristics, and at least one-half of whom are not providers of health care.

(2) For purposes of subparagraphs (A) and (B) of paragraph (1), the term 'provider of health care' means an individual—

(A) who is a direct provider of health care (including a physician, dentist, nurse, podiatrist, or physician assistant) in that the individual's primary current activity is the provision of health care to individuals or the administration of facilities or institutions (including hospitals, long-term care facilities, outpatient facilities, and health maintenance organizations) in which such care is provided and, when required by State law, the individual has received professional training in the provision of such care or in such administration and is licensed or certified for such provision or administration; and

(B) who is an indirect provider of health care in that the individual—

(i) holds a fiduciary position with, or has a fiduciary interest in, any entity described in subclause (II) or (IV) of clause (ii);

(ii) receives (either directly or through his spouse) more than one-tenth of his gross annual income from any one or combination of the following:

(I) Fees or other compensation for research into or instruction in the provision of health care.

(II) Entities engaged in the provision of health care or in such research or instruction.

(III) Producing or supplying drugs or other articles for individuals or entities for use in the provision of or in research into or instruction in the provision of health care.

(IV) Entities engaged in producing drugs or such other articles.

(iii) is a member of the immediate family of an individual described in subparagraph (A) or in clause (i), (ii), or (iv) of subparagraph (B); or

(iv) is engaged in issuing any policy or contract of individual or group health insurance or hospital or medical service benefits.

(d) A center shall have established, in accordance with regulations prescribed by the Secretary, (1) an ongoing quality assurance program (including utilization and peer review systems) respecting the center's services, (2) an integrated medical records system (including a drug use profile) which, in accordance with applicable Federal and State laws respecting confidentiality, is designed to provide access to all past and current information regarding the health status of each

patient and to maintain safeguards to preserve confidentiality and to protect the rights of the patient, (3) a professional advisory board, which is composed of members of the center's professional staff, to advise the governing board in establishing policies governing medical and other services provided by such staff on behalf of the center, and (4) an identifiable administrative unit which shall be responsible for providing the consultation and education services described in subsection (b) (1) (D). The Secretary may waive the requirements of clause (4) with respect to any center if he determines that because of the size of such center or because of other relevant factors the establishment of the administrative unit described in such clause is not warranted.

GRANTS FOR PLANNING COMMUNITY MENTAL HEALTH CENTER PROGRAMS

SEC. 202. (a) The Secretary may make grants to public and non-profit private entities to carry out projects to plan community mental health center programs. In connection with a project to plan a community mental health center program for an area the grant recipient shall (1) assess the needs of the area for mental health services, (2) design a community mental health center program for the area based on such assessment, (3) obtain within the area financial and professional assistance and support for the program, and (4) initiate and encourage continuing community involvement in the development and operation of the program. The amount of any grant under this subsection may not exceed \$75,000.

(b) A grant under subsection (a) for a project shall be made for its costs for the one-year period beginning on the first day of the month in which the grant is made; and, if a grant is made under such subsection for a project, no other grant may be made for such project under such subsection.

(c) The Secretary shall give special consideration to applications submitted for grants under subsection (a) for projects for community mental health centers programs for areas designated by the Secretary as urban or rural poverty areas. No applications for a grant under subsection (a) may be approved unless the application is recommended for approval by the National Advisory Mental Health Council.

(d) There are authorized to be appropriated for payments under grants under subsection (a) \$3,750,000 for the fiscal year 1976, and \$3,750,000 for the fiscal year 1977.

GRANTS FOR INITIAL OPERATION

SEC. 203. (a) (1) The Secretary may make grants to—

(A) public and nonprofit private community mental health centers, and

(B) any public or nonprofit private entity which—

(i) is providing mental health services.

(ii) meets the requirements of section 201 except that it is not providing all of the comprehensive mental health services described in subsection (b) (1) of such section, and

(iii) has a plan satisfactory to the Secretary for the provision of all such services within two years after the date of the receipt of the first grant under this subsection,

to assist them in meeting their costs of operation (other than costs related to construction).

(2) Grants under subsection (a) may only be made for a grantee's costs of operation during the first eight years after its establishment. In the case of a community mental health center or other entity which received a grant under 220 (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975), such center or other entity shall, for purposes of grants under subsection (a), be considered as having been in operation for a number of years equal to the sum of the number of grants in the first series of grants it received under such section and the number of grants it has received under this subsection.

(b)(1) Each grant under subsection (a) to a community mental health center or other entity shall be made for the costs of its operation for the one-year period beginning on the first day of the month in which such grant is made.

(2) No community mental health center may receive more than eight grants under subsection (a). No entity described in subsection (a) (1) (B) may receive more than two grants under subsection (a). In determining the number of grants that a community mental health center has received under subsection (a), there shall be included any grants which the center received under such subsection as an entity described in paragraph (1) (B) of such subsection.

(c) The amount of a grant for any year made under subsection (a) shall be the lesser of the amounts computed under paragraph (1) or (2) as follows:

(1) An amount equal to the amount by which the grantee's projected costs of operation for that year exceed the total of State, local and other funds and of the fees, premiums, and third-party reimbursements which the grantee may reasonably be expected to collect in that year.

(2) (A) Except as provided in subparagraph (B), an amount equal to the following percentages of the grantee's projected costs of operation: 80 per centum of such costs for the first year of its operation, 65 per centum of such costs for the second year of its operation, 35 per centum of such costs for the fourth year of its operation, 30 per centum of such costs for the fifth and sixth years of its operation, and 25 per centum of such costs for the seventh and eighth years of its operation.

(B) In the case of a grantee providing services for persons in an area designated by the Secretary as an urban or rural poverty area, an amount equal to the following percentages of the grantee's projected costs of operation: 90 per centum of such costs for the first two years of its operation, 80 per centum of such costs for the third year of its operation, 70 per centum of such costs for the fourth year of its operation, 60 per centum of such costs for the fifth year of its operation, 50 per centum of such costs for the sixth year of its operation, 40 per centum of such costs for the seventh year of its operation, and 30 per centum of such costs for the eighth year of its operation.

In any year in which a grantee receives a grant under section 204 for consultation and education services, the costs of the grantee's opera-

tion for that year attributable to the provision of such services and its collections in that year for such services shall be disregarded in making a computation under paragraph (1) or (2) respecting a grant under subsection (a) for that year.

(d)(1) There are authorized to be appropriated for payments under initial grants under subsection (a) \$50,000,000 for fiscal year 1976, and \$55,000,000 for fiscal year 1977.

(2) For fiscal year 1977, and for each of the succeeding seven fiscal years, there are authorized to be appropriated such sums as may be necessary to make payments under continuation grants under subsection (a) to community mental health centers and other entities which first received an initial grant under this section for fiscal year 1976, or the next fiscal year and which are eligible for a grant under this section in a fiscal year for which sums are authorized to be appropriated under this paragraph.

(e)(1) Any entity which has not received a grant under subsection (a), which received a grant under section 220, 242, 243, 251, 256, 264, or 271 of this title (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) from appropriations under this title for a fiscal year ending before July 1, 1975, and which would be eligible for another grant under such section from an appropriation for a succeeding fiscal year if such section were not repealed by the Community Mental Health Centers Amendments of 1975 may, in lieu of receiving a grant under subsection (a) of this section, continue to receive a grant under each such repealed section under which it would be so eligible for another grant—

(A) for the number of years and in the amount prescribed for the grant under each such repealed section, except that—

(i) the entity may not receive under this subsection more than two grants under any such repealed section unless it meets the requirements of section 201, and

(ii) the total amount received for any year (as determined under regulations of the Secretary) under the total of the grants made to the entity under this subsection may not exceed the amount by which the entity's projected costs of operation for that year exceed the total collections of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the entity may reasonably be expected to make in that year; and

(B) in accordance with any other terms and conditions applicable to such grant.

In any year in which a grantee under this subsection receives a grant under section 204 for consultation and education services, the staffing costs of the grantee for that year which are attributable to the provision of such services and the grantee's collections in that year for such services shall be disregarded in applying subparagraph (A) and the provisions of the repealed section applicable to determining the amount of the grant the grantee may receive under this subsection for that year.

(2) An entity which receives a grant the authority for which is provided by this subsection may not receive any grant under subsection (a).

(3) There are authorized to be appropriated for fiscal year 1976, and for each of the next six fiscal years such sums as may be necessary to make grants in accordance with paragraph (1).

(f) Unless otherwise specifically provided, a reference in this title to a grant under section 203 includes a grant under subsection (a) of this section and a grant the authority for which is provided by subsection (e) of this section.

GRANTS FOR CONSULTATION AND EDUCATION SERVICES

SEC. 204. (a) (1) The Secretary may make annual grants to any community mental health center for the costs of providing the consultation and education services described in section 201(b) (1) (D) if the center—

(A) received from appropriations for a fiscal year ending before July 1, 1975, a staffing grant under section 220 of this title (as in effect before the date of enactment of the Community Mental Centers Amendments of 1975 and may not because of limitations respecting the period for which grants under that section may be made receive under section 203(e) an additional grant under such section 220; or

(B) has received or is receiving a grant under section 203 and the number of years in which the center has been in operation (as determined in accordance with section 203(a) (2)) is not less than four (or not less than two if the Secretary determines that the center will be unable to adequately provide the consultation and education services described in section 201(b) (1) (D) during the third or fourth years of its operation without a grant under this subsection).

(2) The Secretary may also make annual grants to a public or non-profit private entity—

(A) which has not received any grant under this title (other than a grant under this section as amended by the Community Mental Health Centers Amendments of 1975),

(B) which meets the requirements of section 201 except, in the case of an entity which has not received a grant under this section, the requirement for the provision of consultation and education services described in section 201(b) (1) (D), and

(C) the catchment area of which is not within (in whole or in part) the catchment area of a community mental health center, for the costs of providing such consultation and education services.

(b) The amount of any grant made under subsection (a) shall be determined by the Secretary, but no such grant to a center may exceed the lesser of 100 per centum of such center's costs of providing such consultation and education services during the year for which the grant is made or—

(1) in the case of each of the first two years for which a center receives such grant, the sum of (A) an amount equal to the product of \$0.50 and the population of the center's catchment area, and (B) the lesser of (i) one-half the amount determined under clause (A), or (ii) one-half of the amount received by the center in such year from charges for the provision of such services:

(2) in the case of the third year for which a center receives such a grant, the sum of (A) an amount equal to the product of \$0.50 and the population of the center's catchment area, and (B) the lesser of (i) one-half the amount determined under clause (A), or (ii) one-fourth of the amount received by the center in such year from charges for the provision of such services; and

(3) (A) except as provided in subparagraph (B), in the case of the fourth year and each subsequent year thereafter for which a center receives such a grant, the lesser of (i) the sum of (I) an amount equal to the product of \$0.125 and the population of the center's catchment area, and (II) one-eighth of the amount received by the center in such year from charges for the provision of such services, or (ii) \$50,000; or

(B) in the case of the fourth year and each subsequent year for which a center receives such a grant, the sum of (i) an amount equal to the product of \$0.25 and the population of the center's catchment area, and (ii) the lesser of (I) the amount determined under clause (i) of this subparagraph, or (II) one-fourth of the amount received by the center in such year from charges for the provision for such services if the amount of the last grant received by the center under section 220 of this title (as in effect before the date of the enactment of the Community Mental Health Amendments of 1975) or section 203 of this title, as the case may be, was determined on the basis of the center providing services to persons in an area designated by the Secretary as an urban or rural poverty area.

For purposes of this subsection, the term 'center' includes an entity which receives a grant under subsection (a) (2).

(c) There are authorized to be appropriated for payments under grants under this section \$10,000,000 for fiscal year 1976, and \$15,000,000 for fiscal year 1977.

CONVERSION GRANTS

Sec. 205. (a) The Secretary may make not more than two grants to any public or nonprofit entity which—

(1) has an approved application for a grant under section 203 or 211, and

(2) can reasonably be expected to have an operating deficit, for the period for which a grant is or will be made under such application, which is greater than the amount of the grant the entity is receiving or will receive under such application,

for the entity's reasonable costs in providing mental health services which are described in section 201(b) (1) but which the entity did not provide before the date of the enactment of the Community Mental Health Centers Amendments of 1975.

(b) (1) Each grant under subsection (a) to an entity shall be made for the same period as the period for which the grant under section 203 or 211 for which the entity had an approved application is or will be made.

(2) The amount of any grant under subsection (a) to any entity shall be determined by the Secretary, but no such grant may exceed

that part of the entity's projected operating deficit for the year for which the grant is made which is reasonably attributable to its costs of providing in such year the services with respect to which the grant is made. For purposes of this paragraph, the term 'projected operating deficit' means the excess of an entity's projected costs of operation (including the costs of operation related to the provision of services for which a grant may be made under subsection (a)) for a particular period over the total of the amount of State, local, and other funds (including funds under a grant under section 203, 204, or 211) received by the entity in that period and the fees, premiums, and third-party reimbursements which the entity may reasonably be expected to collect during that period.

(c) There are authorized to be appropriated for payments under grants under subsection (a) \$20,000,000 for fiscal year 1976, and \$20,000,000 for fiscal year 1977.

GENERAL PROVISIONS RESPECTING GRANTS UNDER THIS PART

Sec. 206. (a) (1) No grant may be made under this part to any entity or community mental health center in any State unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237.

(b) No grant may be made under this part unless an application (meeting the requirements of subsection (c)) for such grant has been submitted to, and approved by, the Secretary.

(c) (1) An application for a grant under this part shall be submitted in such form and manner as the Secretary shall prescribe and shall contain such information as the Secretary may require. Except as provided in paragraph (3), an application for a grant under section 203, 204, or 205 shall contain or be supported by assurances satisfactory to the Secretary that—

(A) the community mental health center for which the application is submitted will provide, in accordance with regulations of the Secretary (i) an overall plan and budget that meets the requirements of section 1861(z) of the Social Security Act, and (ii) an effective procedure for developing, compiling, evaluating, and reporting to the Secretary statistics and other information (which the Secretary shall publish and disseminate on a periodic basis and which the center shall disclose at least annually to the general public) relating to (I) the cost of the center's operation, (II) the patterns of use of its services, (III) the availability, accessibility, and acceptability of its services, (IV) the impact of its services upon the mental health of the residents of its catchment area, and (V) such other matters as the Secretary may require;

(B) such community mental health center will in consultation with the residents of its catchment area, review its program of services and the statistics and other information referred to in subparagraph (A) to assure that its services are responsive to the needs of the residents of the catchment area;

(C) to the extent practicable, such community mental health center will enter into cooperative arrangements with health maintenance organizations serving residents of the center's catchment area for the provision through the center of mental health services for the members of such organizations under which arrangements the charges to the health maintenance organizations for such services shall be not less than the actual costs to the center of providing such services;

(D) in the case of a community mental health center serving a population including a substantial proportion of individuals of limited English-speaking ability, the center has (i) developed a plan and made arrangements responsive to the needs of such population for providing services to the extent practicable in the language and cultural context most appropriate to such individuals, and (ii) identified an individual on its staff who is fluent in both that language and English and whose responsibilities shall include providing guidance to such individuals and to appropriate staff members with respect to cultural sensitivities and bridging linguistic and cultural differences;

(E) such community mental health center has (i) established a requirement that the health care of every patient must be under the supervision of a member of the professional staff, and (ii) provided for having a member of the professional staff available to furnish necessary mental health care in case of an emergency;

(F) such community mental health center has provided appropriate methods and procedures for the dispensing and administering of drugs and biologicals;

(G) in the case of an application for a grant under section 203 for a community mental health center which will provide services to persons in an area designated by the Secretary as an urban or rural poverty area, the applicant will use the additional grant funds it receives, because it will provide services to persons in such an area, to provide services to persons in such area who are unable to pay therefor;

(H) such community mental health center will develop a plan for adequate financial support to be available, and will use its best efforts to insure that adequate financial support will be available, to it from Federal sources (other than this part) and non-Federal sources (including, to the maximum extent feasible, reimbursement from the recipients of consultation and education services and screening services provided in accordance with sections 201(b)(1)(D) and 201(b)(1)(E)) so that the center will be able to continue to provide comprehensive mental health services when financial assistance provided under this part is reduced or terminated, as the case may be;

(I) such community mental health center (i) has or will have a contractual or other arrangement with the agency of the State, in which it provides services, which administers or supervises the administration of a State plan approved of all or a part of the of the Social Security Act for the payment of all or a part of the center's costs in providing health services to persons who are

eligible for medical assistance under such a State plan, or (ii) has made or will make every reasonable effort to enter into such an arrangement;

(J) such community mental health center has made or will make and will continue to make every reasonable effort to collect appropriate reimbursement for its costs in providing health services to persons who are entitled to insurance benefits under title XVIII of the Social Security Act, to medical assistance under a State plan approved under title XIX of such Act, or to assistance for medical expenses under any other public assistance program or private health insurance program;

(K) such community mental health center (i) has prepared a schedule of fees or payments for the provision of its services designed to cover its reasonable costs of operation and a corresponding schedule of discounts to be applied to the payment of such fees or payments which discounts are adjusted on the basis of the patient's ability to pay; (ii) has made and will continue to make every reasonable effort (I) to secure from patients payment for services in accordance with such approved schedules, and (II) to collect reimbursement for health services described in subparagraph (J) on the basis of the full amount of fees and payments for such services without application of any discount, and (iii) has submitted to the Secretary such reports as he may require to determine compliance with this subparagraph; and

(L) such community mental health center will adopt and enforce a policy (i) under which fees for the provision of mental health services through the center will be paid to the center, and (ii) which prohibits health professionals who provide such services to patients through the center from providing such services to such patients except through the center.

An application for a grant under section 203 shall also contain a long-range plan for the expansion of the program of the community mental health center for which the application is submitted for the purpose of meeting anticipated increases in demand by residents of the center's catchment area for the comprehensive mental health services described in section 201(b)(1). Such a plan shall include a description of planned growth in the programs of the center, estimates of increased costs arising from such growth, estimates of the portion of such increased costs to be paid from Federal funds, and anticipated sources of non-Federal funds to pay the portion of such increased costs not to be paid from Federal funds.

(2) The Secretary may approve an application for a grant under section 203, 204, or 205 only if the application is recommended for approval by the National Advisory Mental Health Council, the application meets the requirements of paragraph (1), and, except as provided in paragraph (3), the Secretary—

(A) determines that the facilities and equipment of the applicant under the application meet such requirements as the Secretary may prescribe;

(B) determines that—

(i) the application contains or is supported by satisfactory assurances that the comprehensive mental health services (in

the case of an application for a grant under section 203 or 205) or the consultation and education services (in the case of an application for a grant under section 204) to be provided by the applicant will constitute an addition to, or a significant improvement in quality (as determined in accordance with criteria of the Secretary) of, services that would otherwise be provided in the catchment area of the applicant;

(ii) the application contains or is supported by satisfactory assurances that Federal funds made available under section 203, 204, 205, as the case may be, will (I) be used to supplement and, to the extent practical, increase the level of State, local, and other non-Federal funds, including third-party health insurance payments, that would in the absence of such Federal funds be made available for the applicant's comprehensive mental health services, and (II) in no event supplant such State, local, and other non-Federal funds;

(iii) in the case of an applicant which received a grant from appropriations for the preceding fiscal year, during the year for which the grant was made the applicant met, in accordance with the section under which such grant was made, the requirements of section 201 and complied with the assurances which were contained in or supported the applicant's application for such grant; and

(iv) in the case of an application for a grant the amount of which is or may be determined under section 203(c) (2) (B) or 204(b) (3) (B) or under a provision of a repealed section of this title referred to in section 203(e) which authorizes an increase in the ceiling on the amount of a grant to support services to persons in areas designated by the Secretary as urban or rural poverty areas, the application contains or is supported by assurances satisfactory to the Secretary that the services of the applicant will, to the extent feasible, be used by a significant number of persons residing in an area designated by the Secretary as an urban or rural poverty area and requiring such services.

(3) In the case of an application—

(A) for the first grant under section 203(a) for an entity described in section 203(a) (1) (B), or

(B) for the first grant the authority for which is provided by section 203(e),

the Secretary may approve such application without regard to the assurances required by the second sentence of paragraph (1) of this subsection and without regard to the determinations required of the Secretary under paragraph (2) of this subsection if the application contains or is supported by assurances satisfactory to the Secretary that the applicant will undertake, during the period for which such first grant is to be made, such actions as may be necessary to enable the applicant, upon the expiration of such period, to make each of the assurances required by paragraph (1) and to enable the Secretary, upon the expiration of such period, to make each of the determinations required by paragraph (2).

(4) In each fiscal year for which a community mental health center receives a grant under section 203, 204, or 205, such center shall obligate for a program of continuing evaluation of the effectiveness of its programs in serving the needs of the residents of its catchment area and for a review of the quality of the services provided by the center not less than an amount equal to 2 per centum of the amount obligated by the center in the preceding fiscal year for its operating expenses.

(5) The costs for which grants may be made under section 203(a), 204, or 205 shall be determined in the manner prescribed in regulations of the Secretary issued after consultation with the National Advisory Mental Health Council.

(6) An application for a grant under section 203, 204, or 205—

(A) may not be disapproved, and

(B) may not be approved for an amount less than that authorized by such section,

solely on the ground that the applicant has not made reasonable efforts to secure payments or reimbursements in accordance with assurances provided under subparagraphs (I), (J), and (K) of subsection (c)

(1) unless the Secretary first informs such applicant of the respects in which he has not made such reasonable efforts and the manner in which his performance can be improved and gives the applicant a reasonable opportunity to respond. Applications disapproved, and applications approved for reduced amounts, on such grounds shall be referred to the National Advisory Mental Health Council for its review and recommendations respecting such approval or disapproval.

(d) An application for a grant under this part which is submitted to the Secretary shall at the same time be submitted to the State mental health authority for the State in which the project or community mental health center for which the application is submitted is located. A State mental health authority which receives such an application under this subsection may review it and submit its comments to the Secretary within the forty-five-day period beginning on the date the application was received by it. The Secretary shall take action to require an applicant to revise his application or to approve or disapprove an application within the period beginning on the date the State mental health authority submits its comments or on the expiration of such forty-five-day period, whichever occurs first, and ending on the ninetieth day following the date the application was submitted to him.

(e) Not more than 2 per centum of the total amount appropriated under sections 203, 204, and 205 for any fiscal year shall be used by the Secretary to provide directly through the Department technical assistance for program management and for training in program management to community mental health centers which received grants under such sections or to entities which received grants under section 220 of this title in a fiscal year beginning before the date of the enactment of the Community Mental Health Centers Amendments of 1975.

(f) For purposes of subsections (b), (c), (d), and (e) of this section, the term "community mental health center" includes an entity which applies for or has received a grant under section 203 or 204 (a) (2).

PART B—FINANCIAL DISTRESS GRANTS

GRANT AUTHORITY

SEC. 211. The Secretary may make grants for the operation of any community mental health center which—

(1) (A) received a grant under section 220 of this title (as in effect before the date of enactment of the Community Mental Health Centers Amendments of 1975) and, because of limitations in such section 220 respecting the period for which the center may receive grants under such section 220, is not eligible for further grants under that section for a fiscal year beginning after June 30, 1975; or

(B) received a grant or grants under section 203(a) of this title and, because of limitations respecting the period for which grants under such section may be made, is not eligible for further grants under that section; and

(2) demonstrates that without a grant under this section there will be a significant reduction in the types or quality of services provided or there will be an inability to provide the services described in section 201(b).

GRANT REQUIREMENTS

SEC. 212. (a) No grant may be made under section 211 to any community mental health center in any State unless a State plan for the provision of comprehensive mental health services within such State has been submitted to, and approved by, the Secretary under section 237. Any grant under section 211 may be made upon such terms and conditions as the Secretary determines to be reasonable and necessary, including requirements that the community mental health center agree (1) to disclose any financial information or data deemed by the Secretary to be necessary to determine the sources or causes of that center's financial distress, (2) to conduct a comprehensive cost analysis study in cooperation with the Secretary, (3) to carry out appropriate operational and financial reforms on the basis of information obtained in the course of the comprehensive cost analysis study or on the basis of other relevant information, and (4) to use a grant received under section 211 to enable it to provide (within such period as the Secretary may prescribe) the comprehensive mental health services described in section 201(b) and to revise its organization to meet the requirements of sections 201(c) and 201(d).

(b) An application for a grant under section 211 must contain or be supported by the assurances prescribed by subparagraphs (A), (B), (C), (D), (E), (F), (G), (H), (I), (J), (K), and (L) of section 206(c)(1) and assurances satisfactory to the Secretary that the applicant will expend for its operation as a community mental health center during the year for which such grant is sought, an amount of funds (other than funds for construction, as determined by the Secretary) from non-Federal sources which is at least as great as the average annual amount of funds expended by such applicant for such purpose (excluding expenditures of a nonrecurring nature) in the three years immediately preceding the year for which such grant is

sought. The Secretary may not approve such an application unless it has been recommended for approval by the National Advisory Mental Health Council. The requirements of section 206(d) respecting opportunity for review of applications by State mental health authorities and time limitations on actions by the Secretary on applications shall apply with respect to applications submitted for grants under section 211.

(c) Each grant under this section to a grantee shall be made for the projected costs of operation (except the costs of providing the consultation and education services described in section 201(b)(1)(D)) of such grantee for the one-year period beginning on the first day of the first month in which such grant is made. No community mental health center may receive more than three grants under section 211.

(d) The amount of a grant for a community mental health center under section 211 for any year shall be the lesser of the amounts computed under paragraph (1) or (2) as follows:

(1) An amount equal to the amount by which the center's projected costs of operation for that year exceed the total of State, local, and other funds and of the fees, premiums, and third-party reimbursements which the center may reasonably be expected to collect in that year.

(2) An amount equal to the product of—

(A) 90 per centum of the percentage of costs—

(i) which was the ceiling on the grant last made to the center in the first series of grants it received under section 220 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975), or

(ii) prescribed by subsection (c)(2) of section 203 for computation of the last grant to the center under such section,

whichever grant was made last, and

(B) the center's projected costs of operation in the year for which the grant is to be made under section 211.

AUTHORIZATION OF APPROPRIATIONS

SEC. 213. There are authorized to be appropriated \$15,000,000 for fiscal year 1976, and \$15,000,000 for fiscal year 1977 for payments under grants under section 211.

PART C—FACILITIES ASSISTANCE

ASSISTANCE AUTHORITY

SEC. 221. (a) From allotments made under section 227 the Secretary shall pay, in accordance with this part, the Federal share of projects for (1) the acquisition or remodeling, or both, of facilities for community mental health centers, (2) the leasing (for not more than twenty-five years) of facilities for such centers, (3) the construction of new facilities or expansion of existing facilities for community mental health centers if not less than 25 per centum of the residents of

the centers' catchment areas are members of low-income groups (as determined under regulations prescribed by the Secretary), and (4) the initial equipment of a facility acquired, remodeled, leased, constructed, or expanded with financial assistance provided under payments under this part. Payments shall not be made for the construction of a new facility or the expansion of an existing one unless the Secretary determines that it is not feasible for the recipient to acquire or remodel an existing facility.

(b) (1) For purposes of this part, the term 'Federal share' with respect to any project described in subsection (a) means the portion of the cost of such project to be paid by the Federal Government under this part.

(2) The Federal share with respect to any project described in subsection (a) in a State shall be the amount determined by the State agency of the State, but, except as provided in paragraph (3), the Federal share for any such project may not exceed $66\frac{2}{3}$ per centum of the costs of such project or the State's Federal percentage, whichever is the lower. Prior to the approval of the first such project in a State during any fiscal year, the State agency shall give the Secretary written notification of (A) the maximum Federal share, established pursuant to this paragraph, for such projects in such State which the Secretary approves during such fiscal year, and (B) the method for determining the specific Federal share to be paid with respect to any such project; and such maximum Federal share and such method of Federal share determination for such projects in such State during such fiscal year shall not be changed after the approval of the first such project in the State during such fiscal year.

(3) In the case of any community mental health center which provides or will, upon completion of the project for which application has been made under this part, provide services for persons in an area designated by the Secretary as an urban or rural poverty area, the maximum Federal share determined under paragraph (2) may not exceed 90 per centum of the costs of the project.

(4) (A) For purposes of paragraph (2), the Federal percentage for (i) Puerto Rico, Guam, American Samoa, and the Virgin Islands shall be $66\frac{2}{3}$ per centum, and (ii) any other State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the average per capita income of all the States.

(B) The Federal percentages under clause (ii) of subparagraph (A) shall be promulgated by the Secretary, between October 1 and December 13 of each even-numbered year, on the basis of the average of the per capita incomes of each of the States subject to such Federal percentages and of all the States subject to such percentages for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation.

APPROVAL OF PROJECTS

SEC. 222. (a) For each project for a community mental health center facility pursuant to a State plan approved under section 237, there

shall be submitted to the Secretary, through the State agency of the State, an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the project, the application may be filed by one or more of such agencies. Such application shall set forth—

- (1) a description of the site for such project;
- (2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 236;
- (3) except in the case of a leasing project, reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or nonprofit private agency which is to operate the community mental health center;
- (4) reasonable assurance that adequate financial support will be available for the project and for its maintenance and operation when completed;
- (5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on a construction or remodeling project will be paid wages at rates not less than those prevailing on similar construction in the locality as determined by the Secretary of Labor in accordance with the Act of March 3, 1931 (40 U.S.C. 276a—276a-5, known as the Davis-Bacon Act), and the Secretary of Labor shall have with respect to such labor standards the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. Appendix) and section 2 of the Act of June 13, 1934 (40 U.S.C. 276c);
- (6) a certification by the State agency of the Federal share for the project; and
- (7) the assurances described in section 206(c) (2).

Each applicant shall be afforded an opportunity for a hearing before the State agency respecting its application. For purposes of paragraph (3), the term "title" means a fee simple or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of acquisition, remodeling, construction, or expansion of a facility and its operation.

(b) The Secretary shall approve an application submitted in accordance with subsection (a) if—

(1) sufficient funds to pay the Federal share for the project for which the application was submitted are available from the allotment to the State;

(2) the Secretary finds that the application meets the applicable requirements of subsection (a) and the community mental health center for which the application was submitted will meet the requirements of the State plan (under section 237) of the State in which the project is located; and

(3) the Secretary finds that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State, as determined under the State plan.

No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing. The Secretary may not approve an application under this part for a project for a facility for a community mental health center or other entity which received a grant under section 220, 242, 243, 251, 256, 264, or 271 of this title (as in effect before the date of the enactment of the Community Mental Health Centers Amendments of 1975) from appropriations for a fiscal year ending before July 1, 1975, unless the Secretary determines that the application is for a project for a center or entity which upon completion of such project will be able to significantly expand its services and which demonstrates exceptional financial need for assistance under this part for such project. Amendment of any approved application shall be subject to approval in the same manner as an original application.

PAYMENTS

SEC. 223. (a) (1) Upon certification to the Secretary by the State agency, based upon inspection by it, that work has been performed upon a remodeling, construction, or expansion project, or purchases for such a project have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to subsection (c) of this section payment may, after he has given the State agency notice of opportunity for hearing pursuant to such section, be withheld in whole or in part, pending corrective action or action based on such hearing, and (3) the total payments with respect to such project may not exceed an amount equal to the Federal share of the cost of such project.

(2) In case an amendment to an approved application is approved or estimated cost of a remodeling, construction, or expansion project is revised upward any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

(b) Payments from a State allotment for acquisition and leasing projects shall be made in accordance with regulations which the Secretary shall promulgate.

(c) (1) If the Secretary finds that—

(A) a State agency is not substantially complying with the provisions required by section 237 to be in a State plan or with regulations issued under section 236;

(B) any assurance required to be in an application filed under section 222 is not being carried out;

(C) there is substantial failure to carry out plans and specifications approved by the Secretary under section 222; or

(D) adequate State funds are not being provided annually for the direct administration of a State plan approved under section 237,

the Secretary may take the action authorized under paragraph (2) of this subsection if the finding was made after reasonable notice and opportunity for hearing to the involved State agency.

(2) If the Secretary makes a finding described in paragraph (1), he may notify the involved State agency, which is the subject of the finding or which is connected with a project or State plan which is the subject of the finding, that—

(A) no further payments will be made to the State from allotments under section 227; or

(B) no further payments will be made from allotments under section 227 for any project or projects designated by the Secretary as being affected by the action or inaction referred to in subparagraph (A), (B), (C), or (D) of paragraph (1), as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

JUDICIAL REVIEW

SEC. 224. If—

(1) the Secretary refuses to approve an application for a project submitted under section 222, the State agency through which such application was submitted, or

(2) any State is dissatisfied with the Secretary's action under section 223(c) or 237(c), such State,

may appeal to the United States court of appeals for the circuit in which such State agency or State is located, by filing a petition with such court within sixty days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but, until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of facts and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in sec-

tion 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the Court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 225. If any facility of a community mental health center acquired, remodeled, constructed, or expanded with funds provided under this part is, at any time within twenty years after the completion of such remodeling, construction, or expansion or after the date of its acquisition with such funds—

(1) sold or transferred to any person or entity (A) which is not qualified to file an application under section 222, or (B) which is not approved as a transferee by the State agency of the State in which such facility is located, or its successor; or

(2) not used by a community mental health center in the provision of comprehensive mental health services, and the Secretary has not determined that there is good cause for termination of such use,

the United States shall be entitled to recover from either the transferor or the transferee in the case of a sale or transfer or from the owner in the case of termination of use an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the center is situated) of so much of such facility or center as constituted an approved project or projects, as the amount of the Federal participation bore to the acquisition, remodeling, construction, or expansion cost of such project or projects. Such right of recovery shall not constitute a lien upon such facility or center prior to judgment.

NONDUPLICATION

SEC. 226. No grant may be made under the Public Health Service Act for the remodeling, construction, or expansion of a facility for a community mental health center unless the Secretary determines that there are no funds available under this part for the remodeling, construction, or expansion of such facility.

ALLOTMENTS TO STATES

SEC. 227. (a) In each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 228 to the States (with State plans approved under section 237) on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need, of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands in any fiscal year may be less than \$100,000. Sums so allotted to a State other than the Virgin Islands, American Samoa, Guam, and the Trust Territory of the Pacific Islands, in a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose in the next fiscal year (and in such year only), in addition to the sums allotted for such State in such next

fiscal year. Sums so allotted to the Virgin Islands, American Samoa, Guam, or the Trust Territory of the Pacific Islands in a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose in the next two fiscal years (and in such years only), in addition to the sums allotted to such State for such purpose in each of such next two fiscal years.

(b) The amount of an allotment under subsection (a) to a State in a fiscal year which the Secretary determines will not be required by the State during the period for which it is available for the purpose for which allotted shall be available for reallocation by the Secretary from time to time, on such date or dates as he may fix, to other States with respect to which such a determination has not been made, in proportion to the original allotments of such States for such fiscal year, but with such proportionate amount for any of such other States being reduced to the extent it exceeds the sum the Secretary estimates such State needs and will be able to use during such period; and the total of such reductions shall be similarly reallocated among the States whose proportionate amounts were not so ordered. Any amount so reallocated to a State in a fiscal year shall be deemed to be a part of its allotment under subsection (a) in such fiscal year.

AUTHORIZATION OF APPROPRIATIONS

SEC. 228. There are authorized to be appropriated \$5,000,000 for fiscal year 1976, and \$5,000,000 for fiscal year 1977, for allotments under 227.

PART D—RAPE PREVENTION AND CONTROL

RAPE PREVENTION AND CONTROL

SEC. 231. (a) The Secretary shall establish within the National Institute of Mental Health an identifiable administrative unit to be known as the National Center for the Prevention and Control of Rape (hereinafter in this section referred to as the "Center").

(b) (1) The Secretary, acting through the Center, may, directly or by grant, carryout the following:

(A) A continuing study of rape, including a study and investigation of—

(i) the effectiveness of existing Federal, State, and local laws dealing with rape;

(ii) the relationship, if any, between traditional legal and social attitudes toward sexual roles; the act of rape, and the formulation of laws dealing with rape;

(iii) the treatment of the victims of rape by law enforcement agencies, hospitals or other medical institutions, prosecutors, and the courts;

(iv) the causes of rape, identifying to the degree possible—

(I) social conditions which encourage sexual attacks, and

(II) the motives of offenders, and

(v) the impact of rape on the victim and the family of the victim.

- (vi) sexual assaults in correctional institutions;
- (vii) the actual incidence of forcible rape as compared to the reported incidence of forcible rape and the reasons for any difference in such incidences; and
- (viii) the effectiveness of existing private and local and State governmental educational, counseling, and other programs designed to prevent and control rape.

(B) The compilation, analysis, and publication of summaries of the continuing study conducted under subparagraph (A) and the research and demonstration projects conducted under subparagraph (E). The Secretary shall annually submit to the Congress a summary of such study and projects together with recommendations where appropriate.

(C) The development and maintenance of an information clearinghouse with regard to—

- (i) the prevention and control of rape;
- (ii) the treatment and counseling of the victims of rape and their families; and
- (iii) the rehabilitation of offenders.

(D) The compilation and publication of training materials for personnel who are engaged or intend to engage in programs designed to prevent and control rape.

(E) Assistance to community mental health centers and other qualified public and nonprofit private entities in conducting research and demonstration projects concerning the prevention and control of rape, including projects (i) for the planning, developing, implementing, and evaluating of alternative methods used in the prevention and control of rape, the treatment and counseling of the victims of rape and their families, and the rehabilitation of offenders; (ii) for the application of such alternative methods; and (iii) for the promotion of community awareness of the specific locations in which, and the specific social and other conditions under which, sexual attacks are most likely to occur.

(F) Assistance to community mental health centers in meeting the costs of providing consultation and education services respecting rape.

(2) For purposes of this subsection, the term "rape" includes statutory and attempted rape and any other criminal sexual assault (whether homosexual or heterosexual) which involves force or the threat of force.

(c) The Secretary shall appoint an advisory committee to advise, consult with, and make recommendations to him on the implementation of subsection (b). The Secretary shall appoint to such committee persons who are particularly qualified to assist in carrying out the functions of the committee. A majority of the members of the committee shall be women. Members of the advisory committee shall receive compensation at rates, not to exceed the daily equivalent of the annual rate in effect for grade GS-18 of the General Schedule, for each day (including traveltime) they are engaged in the performance of their duties as members of the advisory committee and, while so serving away from their homes or regular places of business, each member shall be allowed travel expenses, including per diem in lieu of subsistence,

in the same manner as authorized by section 5703 of title 5, United States Code, for persons in Government service employed intermittently.

(d) For the purpose of carrying out subsection (b), there are authorized to be appropriated \$7,000,000 for fiscal year 1976, and \$10,000,000 for fiscal year 1977.

PART E—GENERAL PROVISIONS

DEFINITIONS

SEC. 235. For purposes of this title—

(1) The term "State" includes the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

(2) The term "State agency" means the State mental health authority responsible for the mental health service part of a State's plan under section 314(d) of the Public Health Service Act.

(3) The term "Secretary" means the Secretary of Health, Education, and Welfare.

(4) The term "National Advisory Mental Health Council" means the National Advisory Mental Health Council established under section 217 of the Public Health Service Act.

REGULATIONS

SEC. 236. Regulations issued by the Secretary for the administration of this title shall include provisions applicable uniformly to all the States which—

(1) prescribe the general manner in which the State agency of a State shall determine the priority of projects for community mental health centers on the basis of the relative need of the different areas of the State for such centers and their services and require special consideration for projects on the basis of the extent to which a center to be assisted or established upon completion of a project (A) will, alone or in conjunction with other centers owned or operated by the applicant for the project or affiliated or associated with such applicant, provide comprehensive mental health services for residents of an area designated by the Secretary as an urban or rural poverty area, or (B) will be part of or closely associated with a general hospital;

(2) prescribe general standards for facilities and equipment for centers of different classes and in different types of location; and

(3) require that the State plan of a State submitted under section 237 provide for adequate community mental health centers for people residing in the State, and provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor.

The National Advisory Mental Health Council shall be consulted by the Secretary before the issuance of regulations under this section.

STATE PLAN

SEC. 237. (a) A State plan for the provision of comprehensive mental health services within a State shall be comprised of the following two parts:

(1) An administrative part containing provisions respecting the administration of the plan and related matters. Such part shall—

(A) provide for the designation of a State advisory council to consult with the State agency in administering such plan, which council shall include (i) representatives of non-government organizations or groups, and of State agencies concerned with the planning, operation, or use of community mental health centers or other mental health facilities, and (ii) representatives of consumers and providers of the services of such centers and facilities who are familiar with the need for such services;

(B) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports;

(C) provide that the State agency will from time to time, but not less often than annually, review the State plan and submit to the Secretary appropriate modifications thereof which it considers necessary; and

(D) include provisions, meeting such requirements as the Civil Service Commission may prescribe, relating to the establishment and maintenance of personnel standards on a merit basis.

(2) A services and facilities part containing provisions respecting services to be offered within the State by community mental health centers and provisions respecting facilities for such centers. Such part shall—

(A) be consistent with the mental health services part of the State's plan under section 314(d) of the Public Health Service Act;

(B) set forth a program for community mental health centers within the State (i) which is based on a statewide inventory of existing facilities and a survey of need for the comprehensive mental health services described in section 201(b); (ii) which conforms with regulations prescribed by the Secretary under section 236; and (iii) which shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor;

(C) set forth the relative need, determined in accordance with the regulations prescribed under section 236, for the projects included in the program described in subparagraph (B), and, in the case of projects under part C, provide for the completion of such projects in the order of such relative need;

(D) emphasize the provision of outpatient services by community mental health centers as a preferable alternative to inpatient hospital services; and

(E) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title and provide for enforcement of such standards with respect to projects approved by the Secretary under this title.

(b) The State agency shall administer or supervise the administration of the State plan.

(c) A State shall submit a State plan in such form and manner as the Secretary shall by regulation prescribe. The Secretary shall approve any State plan (and any modification thereof) which complies with the requirements of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

(d) (1) At the request of any State, a portion of any allotment or allotments of such State under section 227 for any fiscal year shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the provisions of the State plan approved under this section which relate to projects under part C for facilities for community mental health centers; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or \$50,000, whichever is less, shall be available for such purpose. Amounts made available to any State under this paragraph from its allotment or allotments under section 227 for any fiscal year shall be available only for such expenditures (referred to in the preceding sentence) during such fiscal year or the following fiscal year. Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

(2) Any amount paid under paragraph (1) to any State for any fiscal year for administration of the provisions of an approved State plan shall be paid on condition that there shall be expended from State sources for each year for administration of such provisions not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968.

CATCHMENT AREA REVIEW

SEC. 238. Each State health planning and development agency designated for a State under section 1521 of the Public Health Service Act shall, in consultation with that State's mental health authority, periodically review the catchment areas of the community mental health centers located in that State to (1) insure that the sizes of such areas are such that the services to be provided through the centers (including their satellites) serving the areas are available and accessible to the residents of the areas promptly, as appropriate, (2) insure that the boundaries of such areas conform, to the extent practicable, with relevant boundaries of political subdivisions, school districts, and Federal and State health and social service programs, and (3) insure

that the boundaries of such areas eliminate, to the extent possible, barriers to access to the services of the centers serving the areas, including barriers resulting from an area's physical characteristics, its residential patterns, its economic and social groupings, and available transportation.

STATE CONTROL OF OPERATIONS

SEC. 239. Except as otherwise specifically provided, nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any community mental health center with respect to which any funds have been or may be expended under this title.

RECORDS AND AUDIT

SEC. 240. (a) Each recipient of assistance under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of such assistance, the total cost of the project or undertaking in connection with which such assistance is given or used, and the amount of that portion of the cost of the project or undertaking supplied by other sources, and such other records as will facilitate an effective audit.

(b) The Secretary and the Comptroller General of the United States, or any of their duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients that are pertinent to the assistance received under this title.

NONDUPLICATION

SEC. 21. In determining the amount of any grant under part A, B, or C for the costs of any project there shall be excluded from such costs an amount equal to the sum of (1) the amount of any other Federal grant which the applicant for such grant has obtained, or is assured of obtaining, with respect to such project, and (2) the amount of any non-Federal funds required to be expended as a condition of such other Federal grant.

DETERMINATION OF POVERTY AREA

SEC. 242. For purposes of any determination by the Secretary under this title as to whether any urban or rural area is a poverty area, the Secretary may not determine that an area is an urban or rural poverty area unless—

(1) such area contains one or more subareas which are characterized as subareas of poverty;

(2) the population of such subarea or subareas constitutes a substantial portion of the population of such rural or urban area; and

(3) the project, facility, or activity, in connection with which such determination is made, does, or (when completed or put into

operation) will, serve the needs of the residents of such subarea or subareas.

PROTECTION OF PERSONAL RIGHTS

SEC. 243. In making grants under parts A and B, the Secretary shall take such steps as may be necessary to assure that no individual shall be made the subject of any research involving surgery which is carried out (in whole or in part) with funds under such grants unless such individual explicitly agrees to become a subject of such research.

REIMBURSEMENT

SEC. 244. The Secretary shall, to the extent permitted by law, work with States, private insurers, community mental health centers, and other appropriate entities to assure that community mental health centers shall be eligible for reimbursement for their mental health services to the same extent as general hospitals and other licensed providers.

SHORT TITLE

SEC. 245. This title may be cited as the "Community Mental Health Centers Act".

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MENTAL RETARDATION FACILITIES AND COMMUNITY HEALTH CENTERS CONSTRUCTION ACT OF 1963

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TITLE IV—GENERAL

DEFINITIONS

SEC. 401. For purposes of this Act—

(a) The term “State” includes Puerto Rico, Guam, American Samoa, the Virgin Islands, the Trust Territory of the Pacific Islands, and the District of Columbia.

(b) The term “facility for persons with developmental disabilities” means a facility, or a specified portion of a facility, designed primarily for the delivery of one or more services to persons with one or more developmental disabilities.

[(c) The term “community mental health center” means a facility providing services for the prevention or diagnosis of mental illness, or care and treatment of mentally ill patients, or rehabilitation of such persons, which services are provided principally for persons residing in a particular community or communities in or near which the facility is situated.]

(d) The terms “nonprofit facility for persons with developmental disabilities” [“nonprofit community mental health center”,] and “non-profit private institution of higher learning” mean, respectively, a facility for persons with developmental disabilities, [a community mental health center,] and an institution of higher learning which is owned and operated by one or more nonprofit corporations or associations no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual; and the term “nonprofit private agency or organization” means an agency or organization which is such a corporation or association or which is owned and operated by one or more of such corporations or associations.

(e) The term “construction” includes construction of new buildings, acquisition, expansion, remodeling, and alteration of existing buildings, and initial equipment of any such buildings (including medical transportation facilities); including architect’s fees, but excluding the cost of off-site improvements and the cost of the acquisition of land.

(f) The term “cost of construction” means the amount found by the Secretary to be necessary for the construction of a project.

(g) The term “title”, when used with reference to a site for a project, means a fee simple, or such other estate or interest (including a leasehold on which the rental does not exceed 4 per centum of the value of the land) as the Secretary finds sufficient to assure for a period of not less than fifty years undisturbed use and possession for the purposes of construction and operation of the project.

(h) (1) The term "Federal share" with respect to any project means the portion of the cost of construction of such project to be paid by the Federal Government under part C of title I [or part A of title II].

(2) The Federal share with respect to any project in the State shall be the amount determined by the appropriate State agency designated in the State plan, but except as provided in paragraph (3), the Federal share [(A)] for any project under part C of title I may not exceed 66⅔ per centum of the costs of construction of such project; and (B) for any project under part A of title II may not exceed 66⅔ per centum of the costs of construction of such project or the State's Federal percentage, whichever is the lower]. Prior to the approval of the first such project in the State during any fiscal year, such State agency shall give the Secretary written notification of the maximum Federal share established pursuant to this paragraph for such projects in such State to be approved by the Secretary during such fiscal year and the method for determining the actual Federal share to be paid with respect to such projects; and such maximum Federal share and such method of determination for such projects in such State approved during such fiscal year shall not be changed after the approval of the first such project in the State during such fiscal year.

(3) In the case of any facility or center which provides or will, upon completion of the project for which application has been made under part C of title I [or under part A of title II], provide services for persons in an area designated by the Secretary as an urban or rural poverty area, the maximum Federal share determined under paragraph (2) may not exceed 90 per centum of the costs of construction of the project.

* * * * *

PAYMENTS FOR CONSTRUCTION

SEC. 403. (a) Upon certification to the Secretary by the State agency, designated as provided in section 134 in the case of a facility for the mentally retarded or persons with other developmental disabilities[, or section 204 in the case of a community mental health center.] based upon inspection by it, that work has been performed upon a project, or purchases have been made, in accordance with the approved plans and specifications, and that payment of an installment is due to the applicant, such installment shall be paid to the State, from the applicable allotment of such State, except that (1) if the State is not authorized by law to make payments to the applicant, the payment shall be made directly to the applicant, (2) if the Secretary, after investigation or otherwise, has reason to believe that any act (or failure to act) has occurred requiring action pursuant to section 136 [or section 206, as the case may be.] payment may, after he has given the State agency so designated notice of opportunity for hearing pursuant to such section, be withheld, in whole or in part, pending corrective action or action based on such hearing, and (3) the total of payments under this subsection with respect to such project may not exceed an amount equal to the Federal share of the cost of construction of such project.

(b) In case an amendment to an approved application is approved as provided in section 135 [or 205] or the estimated cost of a project

is revised upward, any additional payment with respect thereto may be made from the applicable allotment of the State for the fiscal year in which such amendment or revision is approved.

(c) (1) At the request of any State, a portion of any allotment or allotments of such State under part A of title II for any fiscal year shall be available to pay one-half (or such smaller share as the State may request) of the expenditures found necessary by the Secretary for the proper and efficient administration of the State plan approved under such part; except that not more than 5 per centum of the total of the allotments of such State for any fiscal year, or \$50,000, whichever is less, shall be available for such purpose. [Amounts made available to any State under this paragraph from its allotment or allotments under part A of title II for any fiscal year shall be available only for such expenditures (referred to in the preceding sentence) during such fiscal year or the following fiscal year.] Payments of amounts due under this paragraph may be made in advance or by way of reimbursement, and in such installments, as the Secretary may determine.

(2) Any amount paid under paragraph (1) to any State for any fiscal year shall be paid on condition that there shall be expended from State sources for such year for administration of the State plan approved under such part A not less than the total amount expended for such purposes from such sources during the fiscal year ending June 30, 1968.

JUDICIAL REVIEW

SEC. 404. If the Secretary refuses to approve any application for a project submitted under section 135 [or 205] the State agency through which such application was submitted, or if any State is dissatisfied with his action under section 134(c) [or 204(b) or section 136 [or 206], such State, may appeal to the United States court of appeals for the circuit in which such State is located, by filing a petition with such court within 60 days after such action. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary, or any officer designated by him for that purpose. The Secretary thereupon shall file in the court the record of the proceedings on which he based his action, as provided in section 2112 of title 28, United States Code. Upon the filing of such petition, the court shall have jurisdiction to affirm the action of the Secretary or to set it aside, in whole or in part, temporarily or permanently, but until the filing of the record, the Secretary may modify or set aside his order. The findings of the Secretary as to the facts, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary to take further evidence, and the Secretary may thereupon make new or modified findings of fact and may modify his previous action, and shall file in the court the record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence. The judgment of the court affirming or setting aside, in whole or in part, any action of the Secretary shall be final, subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code. The commencement of proceedings under this section shall not, unless so specifically ordered by the court, operate as a stay of the Secretary's action.

RECOVERY

SEC. 405. If any facility or center with respect to which funds have been paid under section 403 shall, at any time within twenty years after the completion of construction—

(1) be sold or transferred to any person, agency, or organization (A) which is not qualified to file an application under section 135 [or 205], or (B) which is not approved as a transferee by the State agency designated pursuant to section 134 (in the case of a facility for the mentally retarded or persons with other developmental disabilities) [or section 204 (in case of a community mental health center)], or its successor; or

(2) cease to be a public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities [or community mental health center, as the case may be,] unless the Secretary determines, in accordance with regulations, that there is good cause for releasing the applicant or other owner from the obligation to continue such facility as a public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities [or such center as a community mental health center],

the United States shall be entitled to recover from either the transferor or the transferee (or, in the case of a facility [or center] which has ceased to be public or other nonprofit facility for the mentally retarded or persons with other developmental disabilities [or community mental health center], from the owners thereof) an amount bearing the same ratio to the then value (as determined by the agreement of the parties or by action brought in the district court of the United States for the district in which the center is situated) of so much of such facility [or center] as constituted an approved project or projects, as the amount of the Federal participation bore to the cost of the construction of such project or projects. Such right of recovery shall not constitute a lien upon such facility [or center] prior to judgment.

STATE CONTROL OF OPERATIONS

SEC. 406. Except as otherwise specifically provided, nothing in this Act shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any facility for the mentally retarded or persons with other developmental disabilities [or community mental health center] with respect to which any funds have been or may be expended under this Act.

SEPARATE VIEWS ON H.R. 4925, THE HEALTH REVENUE AND HEALTH SERVICES ACT OF 1975

The Neighborhood Health Centers program has been one of the most useful and cost-effective programs the Federal Government has ever adopted. It delivers quality health services to those who need it at the locations where they live and can take advantage of them. Through preventive care they can avoid many of the illnesses which are so costly, both in terms of treatment, and in terms of disabling bread-winners from full productivity. In the poverty-area located centers, something like 70% of the people have never seen a doctor, and illnesses are discovered that could easily have been avoided had proper medical attention been available.

Throughout the years, the Centers have continuously struggled to become more administratively sound and financially viable. Within recent years studies comparing the cost of providing ambulatory care at Neighborhood Health Centers indicate that these Centers provide as high or higher quality care at competitive costs (e.g. The Neighborhood Health Center in Mount Vernon, New York provides diagnosis through treatment for the cost of \$38.00, while comparable care in a local hospital costs a minimum of \$250.00. This clearly represents a substantial savings).

With rising unemployment in the United States, the twin-edged impact of inflation and recession has affected no group of persons with greater severity than the urban poor and jobless, the elderly, and the migrant worker.

The Ford Administration's proposed budget for Fiscal Year 1976 threatens the health and lives of tens of thousands of people across this nation. By proposing to slash all direct health services by 20 percent, President Ford's desired budget would virtually cut the heart out of the most meaningful and well operated program which came out of the 1960's. As stated by Dr. John L. S. Holloman, President of the Health and Hospitals Corporation of New York City, "As with the rest of our society, when dollars are scarce and economies are to be affected, the money is always taken out of the hides of the poor, who are least powerful."

The 177 Federally-funded Neighborhood Health Centers in the Country provide comprehensive, family oriented ambulatory care to over 1,600,000 poor and working poor. *The Centers are presently being funded at \$200 million for Fiscal Year 1975. The Administration is proposing that the Neighborhood Health Center program be reduced by \$50 million in Fiscal Year 1976 to a funding level of \$150 million. Given this cutback, 68 Centers would be eliminated and 500,000 Neighborhood Health Center patients would be without medical care.*

In New York State, 18 Centers provide quality medical care to 400,000 low-income people. *It is estimated that as a result of the budgetary slashing, New York State would lose 2-3 Centers, 650 jobs*

would be eliminated, and 100,000 persons would lose their primary means of health care. To compound this greivous situation, the Administration is asking that the Federal matching contribution to Medicaid be cut from 50% to 40% in the 13 states with the highest per capita income. (New York State would be the hardest hit.) This proposed policy is based on the assumption that the States would pick up a larger share of the costs for jointly-financed programs. Governor Carey recently stated that the State of New York was not in a position to pick up more than 50% in matching funds and other states are in the same hard-pressed situations.

If these actions are ultimately approved, the total health care system will suffer immeasurably. Our Hospital emergency rooms and outpatient departments are already overburdened. The 12,000 per month newly unemployed who have lost their health benefits are now turning to emergency rooms, out-patient departments, and Neighborhood Health Centers. St. Lukes Hospital in New York City, for example, is so overburdened that persons living beyond the hospital's catchment area are being turned away. The hospital has also instituted a debt level whereby after five unpaid visits, a patient is refused medical care. Many other voluntary hospitals have followed suit and are turning away patients who fail to produce a Medicaid card or other third-party payment.

The overriding question remains whether or not the municipal and voluntary Hospitals across this nation can continue to absorb the ever growing number of indigent patients. Clearly, the answer is no, they cannot.

Our colleagues on the Health subcommittee of the Interstate and Foreign Commerce Committee, under the able guidance of its Chairman, the Honorable Paul G. Rogers, sent to the full Committee, H.R. 4925, which authorizes \$220 million in FY 1976, and \$240 million in FY 1977. We acknowledge that these sums are a substantial increase over the current funding level of \$220 million, but it is our contention that, given the increasing numbers of unemployed seeking medical care in Federally-funded programs, and an inflationary trend of over 14%, the authorization level of H.R. 4925 would fail to support the Centers' present operating budgets.

We believe that the authorization of \$235 million in FY 1976, and \$280 million in FY 1977 more accurately reflects the financial needs of the Neighborhood Centers to continue to fulfill their responsibilities of providing quality medical care to the disabled, elderly, and medically indigent of our nation's communities. Our colleagues in the Senate have noted this fact in their version of this legislation, S. 66, and we would hope that the conferees will review this matter thoroughly and raise the authorization to a more appropriate level.

RICHARD L. OTTINGER.
JOHN M. MURPHY.

ADDITIONAL VIEWS

Although this bill constitutes a conscious effort to increase the role of local citizens in the direction of policy for community mental health centers (CMHC's), the Committee recognizes that state and, especially, local governmental units are making significant contributions in many areas of the country.

The bill provides that all CMHC's operated by governmental units at the date of enactment will continue in their eligibility under the program if the governmental unit will appoint a local citizens advisory committee. Furthermore, the language of the report clearly indicates that the Committee intends to recognize special circumstances where its general rules on governing bodies for CMHC's can be relaxed to allow local governmental units to retain their role as policy-makers.

One such example cited in the report is the situation in eastern Nebraska. I am well familiar with this situation, having served as a Commissioner in Douglas County, Nebraska, when that County and four of its neighbors established a community mental health program in the four catchment areas in those five counties. At present CMHC services are provided in only two of those catchment areas, although the organization intends to extend its program to the other two catchment areas to complete the system. Because the agency is in the midst of completing its program, the Committee felt that it should be allowed to complete the system and operate it as an entity as it was originally planned under the legislation this bill is designed to supplant. This situation is cited as an example. Similar circumstances may well exist in other areas of Nebraska and the country.

It should be recognized by those who are called upon to promulgate regulations to implement this bill should it become public law that 15 Members of the Committee felt that governmental units were making such significant contributions to the program that no restrictions should be placed on their activities. In the compromise language of the report, it is obvious that the Committee recognizes these contributions and only wishes the new governing board procedures to be implemented in areas where no CMHC program is operating and which are not part of an area where a governmental unit has accepted its responsibilities under this program and is in the midst of implementing its program and completing its system.

The Committee is mindful that creation of local citizens governing boards may appear to short-circuit local governments and in no way intends to discourage local government interest in a consulting role for those CMHC's which they do not operate directly.

JOHN Y. MCCOLLISTER, M.C.

MINORITY VIEWS

H.R. 4295—Health Revenue Sharing and Health Services Act

When the Revenue Sharing and Health Services Act was before the Committee and the House of Representatives in the 93rd Congress, there were minority views filed to the Committee Report based upon what were then viewed as serious deficiencies in two of the five programs included in the bill. The objections outlined still pertain in the case of the bill now before us. Both the Migrant Health program and the Community Health Centers program are too complicated and demand that far more services be offered than any small or moderately-sized community can reasonably be expected to supply. The ultimate result of such overblown expectations, as good as they may sound, will be less—and not more—health service for migrants and for communities.

Since the time that the bill was last considered and today, much has transpired which makes the bill subject to more serious objections. When the bill returned from conference in the 93rd Congress, it had grown far beyond the bounds of anything the House of Representatives contemplated when acting upon it initially and far beyond the bounds of any hearings or consideration given by the Committee. Seven programs had been added to the legislation and approximately \$100 million to support them. Those programs are again in the legislation and have been the subject of perfunctory hearings by the Health Subcommittee. The notice of hearings gave one day to Health Revenue Sharing and Developmental Disabilities together explaining this lack of full hearings as follows:

“Both of the above bills were the subject of lengthy hearings in the 93rd Congress, therefore the Department of Health, Education, and Welfare will be the only witness asked to present oral testimony at this hearing.”

That the hearings were lengthy, there is no doubt. The two volumes consume 1307 pages. The attention, however, was upon five programs, namely, Health Revenue Sharing, Family Planning, Community Mental Health Centers, Community Health Centers, and Migrant Health. The bill before us includes, in addition to those five programs, the following programs: Rape Prevention Control, Rat Control, Home Health Services, Committee on Mental Health and Illness of the Elderly, Commission on Epilepsy, Hemophilia Programs, and Commission for Huntington's Disease. If, in the 1307 pages of testimony, there was any significant reference to these latter programs, it was evidently not persuasive enough to move the Subcommittee the first time around to include any of the programs in the final bill presented to either the full Committee or to the House for approval. These programs came to the House full blown from the bill which was passed



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by the other body and were accepted in the conference between the bodies. When the House approved the conference report, these additional programs carried authorizations of about \$100 million. In the present bill, these authorizations have been pared to \$42 million.

In the 93rd Congress, the Health Revenue Sharing bill was vetoed. The basis for that veto was in part the authorization levels throughout, but it was also partly based upon the inclusion of these new programs. The veto message said the following about the final bill:

In H.R. 14214, the Congress not only excessively increased authorizations for existing programs but also created several new ones that would result in an unjustified expenditure of Federal taxpayers' funds. Although the purposes of many of the programs authorized in this bill are certainly worthy, I just cannot approve this legislation because of its effect upon the economy through increased unwarranted Federal spending.

Finally, it should be pointed out that the Federal Government will spend almost \$20 billion in 1975 through Medicare and Medicaid for the financing of health services for priority recipients—aged and low-income persons. These services are provided on the basis of national eligibility standards in Medicare and State eligibility standards in Medicaid and therefore are available to individuals in a more equitable and less restrictive manner than many of the programs authorized in H.R. 14214.

The objections to the seven programs tacked to the bill by the other body go further than authorization levels. They are categorical programs aimed at specific health conditions. It has been long argued by health authorities and to a great extent agreed to by the Committee that singling out specific diseases for special treatment in the end dilutes the health effort and does not materially augment the progress toward eliminating those diseases. It is a further extension of the "disease of the month" concept of health legislation. It is not the kind of legislation which either the Committee or the House intended to approve when the Revenue Sharing and Health Services bill was originally debated and approved in this body. None of these extraneous programs have any place in this legislation and the mere fact that the other body saw fit to include them is not reason for the House of Representatives to accept them.

It is our recommendation that the House not approve and send forward a bill with the certain knowledge that it cannot be approved by the Executive. It is too expensive and it includes far too many diverse programs, some of which are certainly worthy of continuation, but which must suffer from being cast into bad company. The bill should be returned to the Committee to be taken apart so that Members will be able to make meaningful judgments on individual health programs without being castigated for being "anti-health" because they cannot see fit to approve such an all-inclusive package.

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